

Should Aboriginal Healing Traditions Be Integrated into Urban Medical Facilities?

Elena Papadakis

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ABSTRACT

Should Aboriginal Healing Traditions Be Integrated into Urban Medical Facilities?

Elena Papadakis

Should Aboriginal healing traditions be integrated into urban medical facilities? In spite of public and academic interest in bringing the two systems together, existing research on the topic shows how difficult integration would be due to historical/political, practical, and philosophical challenges. Not surprisingly, logistical measures for implementing the task have yet to be formalized. Based on 3.5 months of ethnographic fieldwork in a western Canadian city, this thesis explores what health administrators, people who use Aboriginal healing traditions, and people who practice Aboriginal healing traditions think about integration, and examines how attitudes within and about health care influence participants' views. Mobilizing anthropological concepts about biomedicine, bodily ways of knowing, sensorial dimensions of healing, and multiculturalism, I argue that prevailing attitudes, assumptions, and relations of power within health care culture, *when combined with historical/political, practical, and philosophical challenges*, seriously encumber the integration process. In conclusion, I suggest that Aboriginal healing traditions should only be integrated into urban medical facilities where health care providers and other staff relinquish the attitudes, assumptions, and relations of power that the biomedical paradigm upholds.

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Tables

Table One: Characteristics of Participants

	Ethnicity	Age	Occupation	Yrs Experience	Funding	Gender
Julie	NA	Early 40's	HA - WC	23 years	Prov	F
Crystal	NA	Early 40's	HA - WC	6 years	Prov	F
Sally	NA	Late 20's	HA - HO	6 years	Prov	F
Louise	NA	Early 50's	HA - WC	32 years	Prov	F
Karen	NA	Early 50's	HA - HO	7.5 years	Prov	F
Ashley	NA	----	HA - WC	----	----	F
Jay	NA	Mid 30's	HA - IMF	9 years	Prov	M
Denver	NA	Early 50's	HA - IMF	26 years	Prov; Corp; Ind	M
Susie	A	Early 40's	HA - HO	19 years	Prov	F
Isabelle	A	Mid 60's	HA - WC	12 years	Prov; Fed; Ind	F
Leonard	A	Early 50's	HA - AS	10 years	Various	M
Smiling Stone	A	Mid 50's	AHT Prac	50+ years	----	M
Blackbird	A	Early 70's	AHT Prac	20 years	----	M
Ellen	NA	Early 50's	User of AHT	----	----	F
Jeremy	A	----	User of AHT	----	----	M

Table Two: Kind and Quantity of Information Shared

	Interview	Conversation in Person	Telephone Conversation
Julie	1	0	0
Crystal	1	0	0
Sally	1	0	0
Louise	1	0	0
Karen	1	0	1
Ashley	0	0	1
Jay	1	0	0
Denver	1	0	0
Susie	1	0	1
Isabelle	1	0	0
Leonard	1	1	0
Smiling Stone	1	1	0
Blackbird	0	5	0
Ellen	1	0	0
Jeremy	0	1	0

NA	... Non-Aboriginal	WC	... Walk-in Clinic
A	... Aboriginal	HO	... Hospital
HA	... Health Administrator	IMF	... Integrative Medical Facilities
Prov	... Provincial Government	----	... Not Available or Not Applicable
Fed	... Federal Government	AD	... Addictions Society
Ind	... Individual Donors		
Various	... Various		
User of AHT	... User of Aboriginal Healing Traditions		
AHT Prac	... Aboriginal Healing Traditions Practitioner		

Chapter One Introduction

1.1 Introduction

The 2006 Census shows Canada's Aboriginal population has surpassed the one million mark (1.2 million) with more than half (54%) of Aboriginal people living in Canadian cities and towns --- an increase of 45% in the last decade (Statistic Canada 2006). In response to this trend, health care scholars Hunter, Logan, Goulet, & Barton (2006) have suggested that Aboriginal healing traditions should be integrated into urban medical facilities in an attempt to provide Canada's urban-based Aboriginal population with culturally appropriate care. In particular, they suggest that positive health care experiences manifest upon "using a health care model in which traditional healing approaches are blended with Western healing approaches to health care"—a feat that can be achieved, they argue, "by having both traditional Aboriginal practices and Western services available in the same location" (p. 20-21).

The suggestion to bring these two very different systems together—to be practiced within the same structure—is traceable to health care research that shows Canada's Aboriginal population would benefit from a holistic model of care as defined by Aboriginal peoples (Smylie, 2000) and in relation to Aboriginal worldviews (Correctional Services of Canada, 2000; Royal Commission, 1996).¹ Indeed, Hunter et al. are not the first health care scholars to propose that Aboriginal and Western medicine should integrate. For example, in Cook's (2005) study on the use of traditional Mi'kmaq medicine among patients at an Aboriginal health center, it is suggested that health

¹ It can also be said that Canada's health care system does not provide a framework that adequately addresses psychosocial illnesses or trauma stemming from the historical oppression of Aboriginal peoples through colonization and residential schooling (see further Waldram, 1997).

professionals and Aboriginal healers should find ways of integrating Mi'kmaq and Western medicine (p. 96), because Mi'kmaq patients believe the former is more effective than the latter (p. 98). Similarly, in Broome & Broome's (2007) essay on Native American healing traditions, it is noted, "collaboration between traditional healers and Western practitioners is an important step towards providing more holistic care" (p. 163). In a similar study by Marbella, Harris, Diehr, Ignace, & Ignace (2006), it is recommended, "movement toward integrative health practices between traditional healers and physicians could prove to be beneficial to patients" (p. 185). The World Health Organization (2002) has likewise declared that one of its roles is to support the integration of traditional medicine into national health care systems (p. 2).

In contrast to these propositions, anthropological and sociological research on the topic (e.g. Martin-Hill, 2003; Benoit, Carroll, & Chaudhry, 2003) shows how difficult integration would be due to historical/political challenges (e.g. Aboriginal peoples' distrust of the "dominant" society) as well as practical and philosophical incongruities between the systems themselves (e.g. Aboriginal healing traditions are spirit-centered and biomedicine is not). Not surprisingly, logistical measures for implementing the task have yet to be formalized and a number of pertinent questions remain unanswered. For example, are certain kinds of medical facilities better suited to the task than others? Are certain types of health care models more apt at delivering Aboriginal healing traditions to the satisfaction of its users and practitioners? And, how might the attitudes, assumptions, and relations of power within health care culture—the culture of biomedicine—effectively facilitate or hinder the process? Indeed, one wonders to what extent and under what circumstances the two systems can and should interact. In fact, this latter point is

the very center of my research question: *Should Aboriginal healing traditions be integrated into urban medical facilities?*

In an attempt to address this question, this thesis draws upon concepts from critical medical anthropology, the anthropology of embodiment, the anthropology of the senses, and feminist theory in exploration of what health administrators and users and practitioners of Aboriginal healing traditions think about integration. To be exact, the participants who helped to inform this study share their views on the following five topics: a) biomedicine; b) Aboriginal healing traditions; c) holistic health; d) health care delivery models and attitudes within health care; and e) sensorial dimensions of healing. Furthermore, this thesis involves an analysis of health care scholarship in an attempt to ascertain the propensity of prevailing health care delivery models to facilitate the use of Aboriginal healing traditions within urban medical facilities. As such, this thesis should be understood as an exercise in applied medical anthropology which seeks to accomplish the following three objectives: 1) to explore widespread health care models and prevailing attitudes and beliefs within and about health care; 2) to articulate what health administrators, practitioners of Aboriginal healing traditions, and people who use Aboriginal healing traditions think about the integration of Aboriginal and Western medicine; and 3) to establish an anthropologically informed discussion about the use of Aboriginal healing traditions within urban medical facilities that may be used to inform health care policy.

Given this thesis entails an analysis of health care delivery models, attitudes, assumptions, and relations of power within health care culture, the information produced as a result of this work speaks to health care delivery in its broader context; that is to say,

this work has relevance to any and all people who use Canada's health care system. Moreover, because this research draws upon concepts pertaining to bodily ways of knowing, sensorial dimensions of healing, and multiculturalism, it contributes to these discourses in the following ways: a) it both highlights and problematizes experiential knowledge as a measure for the transfer and acquisition of cultural knowledge in health care contexts; b) it shows that the practical means for tending to holistic health and spirituality differ both cross-culturally and between individuals—they look, feel, smell, taste, and sound different. These tangible variations, I argue, have real consequences in biomedical contexts especially when they deviate from current norms; and c) following Anne Phillips in her most recent book *Multiculturalism without Culture* (2007), I argue for a concept of culture that, like gender and class, influences people but does not determine their actions—a concept of culture with enough “structure” so that it may serve as a vehicle for political agency, yet flexible enough to allow for diversity within. Such a concept, I argue, affords an ideological space for those individuals who are in colonial relations with the Canadian state (indeed I am referring to Aboriginal peoples), yet recognizes the diversity across and within Aboriginal cultures—including the various ways in which Aboriginal people conceptualize and enact “healing traditions”. However, although I support this particular concept of culture, I maintain that it will only serve the people who use and practice Aboriginal healing traditions if it translates to the creation of physical space for Aboriginal healing traditions in all of their complexities. Such a situation, I argue, can only be realized in health care contexts where the beliefs, needs, and preferences of the people who use and practice Aboriginal healing traditions are deemed as important as those of physicians and other authoritative figures. This, to be

sure, is representative of my personal views about the use of Aboriginal healing traditions in urban medical facilities.

1.2 Theoretical viewpoints

Critical Medical Anthropology: According to Margaret Lock and Nancy Scheper-Hughes (1996), the aim of critical medical anthropology is not simply to study “alternative” medicine and practices, it is to show how “all knowledge relating to the body, health, and illness is culturally constructed, negotiated, and renegotiated in a dynamic process through time and space” (p. 43). It is by virtue of this assertion that I am in a position to talk about the concept “health care culture” with credence. In the context of my research, this concept is pivotal because it affords a unified space for the comparison of health care providers’ attitudes and assumptions. In other words, because there is such a thing as “health care culture”, I am able to talk about its various components and the ways in which they interact. For example, I maintain that Cartesian dualism, with its split between mind and body, spirit and matter, and real and unreal (Lock & Scheper-Hughes, 1987: 7), is a component of health care culture. As such, I make the assumption that the people in this study who believe Aboriginal healing traditions are only psychologically beneficial have been influenced by Cartesian dualism.

In line with the aims of critical medical anthropologist Naomi Adelson (2000), I embrace the view that “understandings of health and well-being are always historically and culturally mediated” (p. 3). In her book, *Being Alive Well: Health and the Politics of Cree Wellbeing*, Adelson explores the concept of health in the context of Cree culture and resolves that “health is less determined by bodily function than by the practices of daily living and by the balance of human relationships intrinsic to Cree lifestyle” (p.15).

Adelson's work has relevance to my research insofar as it provides a basis for my views on holism (holistic health): I argue that constructions of holism, like constructions of health, are conceived and enacted differently across cultures and, I would add, between individuals.

Medical anthropologist James Waldram's exploration of Aboriginal spirituality in Canadian prisons is pertinent to my research also. In his 1997 book, *The Way of the Pipe: Aboriginal Spirituality and Symbolic Healing in Canadian Prisons*, Waldram explores how and why Aboriginal spirituality operates as a form of therapy—a therapy that is not recognized as a valid form of rehabilitation according to the mental health policies and guidelines of most Canadian prisons (x). The efficacy of Aboriginal healing traditions is likewise undermined within biomedical contexts thus making Waldram's work an appropriate resource for me to draw upon. Waldram's (2004) most recent book, *Revenge of the Windigo: The Construction of the Mind and Mental Health of North American Aboriginal Peoples*, explores what scholars and researchers *think* they know about Aboriginal peoples' mental abilities, mental health, and mental illness, and on what basis they think they know it. My research is comparable to the extent that it explores health administrators' perceptions of Aboriginal healing traditions and how (on what basis) they believe it works.

The Anthropology of Embodiment: The anthropology of embodiment² brings phenomenological perspectives to the discipline. This relatively new field is the product of two distinct yet complementary theoretical perspectives: 1) Merleau-Ponty's theory of perception; and 2) Bourdieu's theory of practice (Lock, 1987; Csordas, 1993).

² The anthropology of embodiment refers here to bodily ways of knowing as explored by Thomas Csordas (1993) and Michael Jackson (1995).

Embodiment features prominently in the works of Thomas Csordas (e.g. 1995; 2002; 1997; 1993), who enthusiastically supports embodiment as a paradigm for research in anthropology (Lock, 1987: 138). Csordas (1993) uses the term “somatic modes of attention” to refer to the processes by which the body attends to and with itself. In particular, Csordas writes:

Somatic modes of attention are culturally elaborated ways of attending to and with one’s body in surroundings that include the embodied presence of others. Because attention implies both sensory engagement and an object, we must emphasize that our working definition refers both to attending “with” and attending “to” the body (p. 138).

Anthropologist Michael Jackson has also contributed to theoretical discourse on bodily awareness, however his theory of embodiment principally concerns intersubjectivity, a concept that takes center stage in his book *At home in the world* (1995). Guided by his belief that the definitive, categorical nature of Western thought deters us from perceiving the co-relational existence of subject and object (p. 18), Jackson seeks to illuminate the vitality of subjective action; the energetic process by which objects come to embody the energies of the subjects that work upon them. Likewise, Jackson seeks to show how the reverse is possible, how subjects come to embody the energies of the objects upon which they work. Influenced by Heidegger’s concept “knowing is doing”, Jackson draws attention to the relationship between body-knowledge and human agency, i.e., human agency amounts to doing, and doing amounts to knowing. Consider, for example, the following passages: “For Frank and the other men, knowledge was something you lived. It wasn’t something you bore in mind but never acted upon” (p. 145); “In his view, a man of knowledge (*pinangkalpa*) knew things firsthand. Just listening to what people say only takes you half way” (p. 166).

According to some of the participants in this study, emotional and experiential knowledge is more conducive to understanding than mental knowledge. I therefore draw upon embodiment as a conceptual base point for discussions on the transfer and acquisition of knowledge.

The Anthropology of the Senses: Inspired by ethnographic and philosophical discourses on the body and bodily ways of knowing, the anthropology of the senses documents cross-cultural instances of sensorial modes of intelligence (Howes, 1991: 3-4). Different from the anthropology of embodiment, the anthropology of the senses seeks to show that bodily ways of knowing are not simply organic, physiological processes; they are historically, politically and, ultimately, culturally informed. David Howes (2004) elaborates: “it is not enough to look at the senses as ‘energy transducers, ‘information gatherers’, or ‘perceptual systems’; they must be understood as cultural systems” (p. 4-5). Further, Howes maintains that sensorial anthropologists (anthropologists who study the senses) are concerned with questions such as: “What is the relative importance and meaning of the different senses to the members of that culture? How does that culture’s map of the senses differ from ours?” (p. 168-19). I have found the anthropology of the senses to be useful in exploring participants’ views on the use of Aboriginal healing traditions within urban medical facilities. For example, one of the aims of the anthropology of the senses is to expose the west’s classical diminution of the senses of smell, touch, and taste (Howes, 2004: 10). Given that Aboriginal healing traditions have multi-sensorial dimensions,³ I explore how participants’ views on the use of Aboriginal

³ Although Aboriginal healing traditions have sensorial dimensions—that is, they engage the body’s sensorial faculties—they are not necessarily intended to engage people’s senses, but rather people’s spirit and spirits in general.

healing traditions within urban medical facilities are influenced by the meanings they attribute to sensorial dimensions of healing.

Feminist Theory: My views about culture and multiculturalism are grounded in theoretical viewpoints from feminist theory. For the most part, I draw upon and support Anne Phillips' (2003, 2007) notion of culture, which I discuss at greater length in the terminology section directly below. Nancy Fraser's (2003) work on recognition and redistribution—a reformulation of her previous work (e.g. 1995)—is also relevant to my research, however, more often than not, I am critical of her work. This is apparent, for example, in the terminology section whereupon I discuss my views pertaining to the terms “Aboriginal” and “non-Aboriginal”.

1.3 Terminology

Aboriginal and Non-Aboriginal: The term “Aboriginal” refers to those people who identify themselves as Métis, First Nations, and Inuit,⁴ and the term “non-Aboriginal” refers to those people who do not. I am aware that these terms may be seen as essentialist. They do not, for example, recognize distinct cultural diversity within these categories nor do they obviate the ways in which people experience life insofar as gender, age, or class. Some might even say these terms are driven by what Nancy Fraser calls “the identity model of recognition” (see Fraser, 2003); a model of recognition “that puts moral pressure on individual members to conform to group culture” (Fraser, 2003: 26), which effectively imposes “a drastically simplified group identity, which denies the complexities of people’s lives, the multiplicity of their identifications, and the cross-pulls

⁴ Given that my research is situated in an urban environment and is informed by First Nations, Métis, and Inuit perspectives alike, the term “Aboriginal” is particularly well suited.

of their various affiliations” (p. 26). Indeed, I am aware of these criticisms. However, I remain partial to the terms “Aboriginal” and “non-Aboriginal” because of the implicit, poignant information they convey. The point, in my mind, is to make clear the distinction between those peoples who continue to be in colonial relations with the Canadian state and those who are not.⁵ There is no question: Canada’s Aboriginal population has a different kind of relationship with the Canadian government than other cultural groups, thus, in spite of the fact that Aboriginal peoples constitute but one of Canada’s multiple cultures, they are not, per say, “on par” with Canada’s multi-cultural population. To be clear, I do not mean to imply that all of the individuals who comprise Canada’s non-Aboriginal multi-cultural population experience life in Canada the same way. However, no matter how different Canada’s non-Aboriginal multi-cultural groups may be from one another, they are mutually unmarked as having colonial relations with the Canadian state—a mark that is exclusive to Aboriginal Canadians only. In effect, these terms serve to signal and/or distinguish *politically* distinct social actors in spite of the fact that they simplify rather than complexify intra-cultural dynamics (age, gender, class). In other words, these terms are valuable and/or useful because they are vehicles for political agency.

This said, I am likewise critical of what Fraser (2003) calls “the status model of recognition”, a model that understands recognition as “a question of status” (p. 29). Thus, whereas the identity model of recognition understands misrecognition in terms of “psychical deformation” and “cultural harm” (p. 27), the status model of recognition understands misrecognition in terms of “institutionalized relations of social

⁵ As a note, to be in *colonial* relations with the Canadian state is distinct from the situation in which a minority culture is subjugated by the majority culture. The political tension between Quebec and English Canada (separatist politics) comes to mind, but this is debatable.

subordination” (p. 27) or “institutionalized harm” (p. 29). In other words, her solution to the problem of recognition is to replace “institutionalized value patterns that impede parity of participation with patterns that enable or foster it” (p. 28). In particular, she argues, “what requires recognition is not group-specific identity but rather the status of individual group members as full partners in social interaction” (p. 27).

My argument against such a “non-identitarian” (p. 32) model of recognition is that it dissolves the capacity of collective identities—such as “Aboriginal”—to serve as political collectivities. Here, my views are consistent with Anne Phillips (2003). According to Phillips, when Fraser “recasts recognition struggles, not as claims about collective identities, but as seeking to establish the subordinated individuals as full partners in social life...recognition no longer requires any assertion about the validity of the group identity, for it is the individuals who are to be recognized as full partners rather than the groups to which they belong” (p. 272). This is worrisome, according to Phillips, because “some of the struggles for political voice may require strong assertion of agency even if not necessarily a strong assertion of group distinctiveness and worth” (p. 273). Indeed, I think Phillips is correct when she says, “struggles for recognition are and have been very much struggles for political voice” (p. 265) and unless some groups are marked as distinct “they will have a limited influence on the formation of public policy” (p. 265).

With this discussion in mind, I posit the following argument: Although the “Aboriginal” healing traditions described in this thesis may not represent the beliefs and health practices of each and every Aboriginal Canadian, the term (and collective identity) “Aboriginal” is useful nonetheless because it affords a conceptual space for those Canadians who are in colonial relations with the Canadian state. As general and

homogenous a space it may be, it is a space all the same. When understood in this way, then, the term “Aboriginal” functions “as a means to *further* ends rather than an end in itself (Phillips, 2003: 266 emphasis added). In other words, Aboriginal Canadians—in all of their complexities and identifications—may use the term “Aboriginal” as “a foot in the door”, so to speak, to establish some political clout within Canada’s health care framework.

Aboriginal Approaches to Health and Medicine: Aboriginal approaches to health and medicine vary through time and space and are realized in different ways between Aboriginal cultures and individuals. This broad category comprises all of the means through which spiritual, emotional, mental and physical dimensions of self are nurtured. To have health or to be in health is to enjoy a balance of these four dimensions of self.⁶

Aboriginal Healing Traditions: In the context of my research, the expression “Aboriginal healing traditions” refers specifically to those activities typically facilitated by shamans, healers, medicine men and women, and Elders. Thus, whereas Aboriginal approaches to health and medicine may include activities such as consuming traditional remedies, spending time with friends, and getting enough sleep, Aboriginal healing traditions refers to pipe ceremonies, healing and talking circles, sweats (participating in sweat lodge ceremonies), drumming, and sacred songs. These traditions are themselves components of Aboriginal spirituality (see further Waldram, 1997). The term “traditions”, in the context of the expression “Aboriginal healing traditions”, does not refer to the word in the conventional sense—as long-established, unchanging practices—but is meant to reflect a series of activities that oscillate in relation to various circumstances (e.g. social, environmental, economic). Cultural anthropologist Marshal

⁶ Smiling Stone, a practitioner of Aboriginal healing traditions, explained this to me.

Sahlins (1999) has influenced my views about tradition. In particular, he writes: “traditions are invented in the specific terms of the people who construct them” (p. 408). For example, in the past, medicine men and women were commonly paid for their services with tobacco, food, blankets, and other household provision. Nowadays, however, it is becoming more common for such professionals to be paid with money (honorariums) because they, like most people in this day and age, have bills to pay.

Medical Facilities: The term “medical facilities” encompasses hospitals and walk-in clinics. By and large, the kind of medicine delivered in these contexts is biomedicine, also commonly known as “Western medicine” or “conventional medicine”.

Integrative Medical Facilities: Integrative medical facilities adhere to the philosophy of integrative medicine. According to Maizes, Schneider, Bell, & Weil (2002), “integrative medicine is defined much more broadly than CAM [complementary and alternative medicine]. It is healing-oriented medicine that reemphasizes the relationship between patient and physician, and integrates the best of complementary and alternative medicine with the best of conventional medicine” (p. 851).

Sensory-Friendly Medical Facilities: A sensory-friendly medical facility is a hypothetical concept. In my mind, a sensory-friendly facility is capable of managing auditory, olfactory, and visual byproducts of multi-sensorial cross-cultural approaches to health and medicine. For example, a sensory-friendly facility would be able to accommodate smudging because it would be systematically and/or technologically provisioned to do so (e.g. adequate ventilation).

Biomedical Paradigmatic Constraints: I consciously chose the term “biomedical paradigmatic constraints” for the purpose of describing the limits of Canada’s current

health care model without making reference to the term biomedical hegemony. Following Thomas Csordas' critique of critical medical anthropology (1988), it is my belief that the term biomedical hegemony, commonly favored by critical medical anthropologists, is mistakenly predicated upon the idea that it itself constitutes the "ruling" class.⁷ In particular, Csordas writes:

Insofar as the concept of hegemony denies ideological distinction among social domains, it can be said that hegemony is imminent in biomedicine, but not that there is biomedical hegemony. The medical student, who says not that she is opposed to socialized medicine, but that it is unrealistic, is not a member of the ruling class (p. 417).

When I talk about biomedical paradigmatic constraints, then, I am referring to systematic characteristics of biomedicine. For example, when health care providers enact the credo "equality of care" as "treat everyone the same", it is constraining to those patients who believe that health care should be tailored to their personal needs and preferences.⁸ To cite another example, clinical trials and evidence-based research are biomedical paradigmatic constraints for those people who wish to demonstrate the efficacy of certain alternative therapies: Spirit cleansing, for example, simply cannot be "clinically proven". That physicians have a lot of power—a well-studied phenomenon in physician/patient discourse analysis (e.g. Li et al., 2007)—is another biomedical paradigmatic constraint that affects the needs and preferences of patients and other health care providers who have less authority. For example, nurses who believe that health care should be patient-centered—that is, tailored to patients' individual needs and preferences—find themselves

⁷ My views pertaining to the use of the term biomedical hegemony does not obliterate my otherwise partiality to the aims of critical medical anthropology overall.

⁸ To clarify, some of the participants in this study do not *enact* the concept equality of care the same way they *interpret* and/or describe it.

in thorny situations when, simultaneously, they do not want to upset and/or inconvenience their supervisors in the hierarchical institutions in which they work. True enough, such nurses do not have to adhere to the needs and preferences of physicians, but if they do not, they risk their jobs. In this way, the biomedical paradigm is more of a tension than a constraint because it does not necessarily constrict nurses from providing patient-centered care.⁹ In light of these examples, then, I interpret the term “biomedical paradigmatic constraints” on a continuum—a paradigm that is constraining in varying degrees.

The Dominant Society: The term “the dominant society” is conceptually opaque and requires some explanation. This term was used by some of the participants in this study to signify: a) the Canadian state; and b) non-Aboriginal people. It was often used in the context “Aboriginal people don’t trust the dominant society”, thus referring to the historical oppression, cultural assimilation, and genocide of Aboriginal peoples by the Canadian state. It was also used in the context, “Aboriginal healing traditions are not accepted by members of the dominant society”, thus referring to non-Aboriginal people in general. In retrospect, I should have asked participants to define exactly what they meant by “the dominant society”, but it did not occur to me at the time. In her essay titled, “Discourses influencing nurses’ perceptions of First Nations patients”, nursing scholar Annette Browne (2005) draws upon anthropologist Elizabeth Furniss’ (1999) description of the term “the dominant culture”. In particular, Browne writes:

⁹ Anne Phillips’ (2007) critique of Kukatha’s (2003) notion of cultural “exit” speaks to this predicament. Specifically, Phillips argues that we should not assume that people who acquiesce to their culture’s practices necessarily consider those practices as “right and just” or “are living according to the principles of their choice” (p. 136).

[The term “the dominant culture”] does not imply that there is a unitary dominant culture, that all people subscribe to dominant cultural assumptions, or that these assumptions are static or fixed. However, various kinds of dominant cultural assumptions infuse many aspects of everyday life—through the media, schoolbooks, public interest debates, and everyday conversation. They shift and change according to one’s life context, the local issues of which they are apart, and current political and economic contexts (p. 65).

I think this description is helpful for understanding the term “the dominant society” as I employ it in the context of this thesis.

Culturally Competent Health Care: Rooted in the well-established tradition of transcultural nursing,¹⁰ culturally competent health care is a framework for health care delivery involving ethnic minority patients. This concept—well known to both health care scholars and providers—aims to impart health care providers with “knowledge and skills to address ‘cross-cultural’ challenges in clinical encounters” (Kleinman, 2004: 954). Accordingly, health care providers who are “culturally competent” are thus in a position to facilitate and/or enhance the delivery of biomedical care to minority patients. I discuss this concept at greater length in Chapter 3.

Patient-Centered Care: Patient-centered care, devised by medical doctor Ian McWhinney in the 1970’s, is a relatively new conceptual framework for health care delivery. Moving away from the disease-centered model of care, patient-centered care encourages patients to become “active participants in their own care” and likewise advocates for health care services that focus on patients’ “individual needs and

¹⁰ “Transcultural nursing” was founded by Madeleine Leininger (RN, PhD in Anthropology) in the mid 1950s (Rodriguez, 2008). This concept characterizes “culture” or “cultural groups” in terms of difference and maintains that all “cultures” or “cultural groups” should respect one another as *equals* (Polaschek, 1998). Transcultural nurses specialize in assisting others “to become sensitive to and knowledgeable about diverse cultures” (Murphy, 2005: 142).

preferences, in addition to advice and counsel from health professionals” (Stanton, 2002:

1). I discuss this concept at greater length in Chapter 3.

Cultural Safety: Designed by Maori nursing researchers in the late 1980’s, cultural safety is a bi-cultural framework for health care delivery involving Indigenous patients.¹¹ Its basic premise: Health care providers should seek to cultivate health care environments that are culturally “safe” and effectively nurture Indigenous peoples and identities (Polaschek, 1998). As with culturally competent health care and patient-centered care, I discuss this concept at greater length in Chapter 3.

1.4 Sources of information

This thesis is grounded in original ethnographic research involving health administrators, practitioners of Aboriginal healing traditions, and people who use Aboriginal healing traditions. It also draws upon health care scholarship in which prevailing attitudes and beliefs within health care are apparent.

Health Administrators: Typically, health administrators are responsible for logistical and often times educational components of health care delivery and thus have a good understanding of the kinds of programs, philosophies, and medical practices that their facilities may or may not be inclined (or able) to uphold.

The health administrators who helped to inform this study include: **Denver** (age fifty something), a non-Aboriginal chief executive officer who works at an integrative medical facility; **Leonard** (age fifty something), an Aboriginal executive director who works at an Aboriginal addictions society; **Julie** (age forty something), **Louise** (age fifty

¹¹ In contrast to transcultural nursing ideology that puts all cultures on par, bicultural nursing ideology differentiates between “original peoples” and “subsequent arrivals” (Polaschek, 1998). As such, culturally competent health care and cultural-safety are ideologically at odds.

something), and **Crystal** (age fifty something), all non-Aboriginal walk-in clinic managers; **Karen** (age fifty something), a non-Aboriginal director of cultural services who works at a hospital; **Susie** (age forty something) and **Sally** (age twenty something), both hospital-based nurse clinicians, the former is Aboriginal and the latter is not; **Ashley** (age not provided), a non-Aboriginal community health worker; **Isabelle** (age sixty something) an Aboriginal walk-in clinic board member; and **Jay**, a non-Aboriginal physician with administrative clout. Most of these participants were educated in either nursing or medicine but are not currently working as nurses or physicians in the traditional sense (e.g. bedside nurses, general practitioners, etc.).¹²

Practitioners of Aboriginal Healing Traditions (Practitioners of AHT): The two practitioners of AHT who helped to inform this study, **Blackbird** (age seventy something) and **Smiling Stone** (age fifty something), identified themselves as medicine men (they are both in fact Aboriginal males), having both “doctor” and “priest” like duties. In the context of my research, however, I have chosen to alternate between the terms “practitioners of AHT” and “AHT practitioners” because they allow me to talk about shamans, healers, medicine men and women, Elders, and spiritual support persons more succinctly. Shamans, according to Waldrum (1997), are “special spiritualists and healers whose knowledge and abilities rise above the more common, practical medical knowledge as embodied in herbalists and other healers” (p. 100). By maintaining a close relationship with their guardian spirits, shamans are able to communicate with the spirit world directly (p. 100). According to an anonymous pamphlet given to me by Blackbird, a healer is someone who lives his or her life adhering to the concept “think for yourself,

¹² Please see “Table One: Characteristics of Participants” on page vii and “Table Two: Kind and Quality of Information Shared” on page vii.

live for others”. Prior to healing others, however, a “true” healer is obliged to deal with matters of his or her own health: He or she has to be healed in order to heal. Similarly, Waldram (1997) notes that “healer” or “Elder” status “denotes a great deal of wisdom and experience, and the living of an ideal ‘Aboriginal’ lifestyle” (p. 109). Notably, not all Elders are seniors: Young people who demonstrate outstanding wisdom, i.e., they practice what they teach, may attain Elder status also.¹³ The term “spiritual support persons” is commonly used in biomedical contexts when referring to any or all of the above.¹⁴

Users of Aboriginal Healing Traditions (Users of AHT): The users of AHT who helped to inform this study comprise two people. The first person, **Jeremy** (who is Aboriginal), is someone with whom I personally experienced Aboriginal healing traditions.¹⁵ The second person, **Ellen** (who is non-Aboriginal), relayed her experiences to me over lunch. Not only do Jeremy and Ellen offer first-hand, qualitative information about Aboriginal healing traditions, they offer their thoughts on the challenges and risks associated with the use of Aboriginal healing traditions in urban medical facilities.

Health Care Scholarship: In an attempt to expose some of the prevailing attitudes and beliefs within health care culture, I investigate the ways in which health care researchers interpret and actualize health care delivery models and/or concepts, including: culturally competent health care; patient-centered care; and cultural safety. To be sure, these models and/or concepts are rooted in healthcare ideologies about health,

¹³ I read this in an anonymous resource given to me by Blackbird.

¹⁴ Susie explained the meaning of this term to me.

¹⁵ We participated in a healing circle on one occasion.

healthcare delivery, and culture. In particular, I examine whether these health care models and/or concepts are capable of creating a situation in which Aboriginal healing traditions can be integrated into urban medical facilities with integrity. Given that my analysis of these models and/or concepts is indeed critical (I investigate their strengths and weaknesses) I am engaging in discourse analysis.¹⁶ Furthermore, it is necessary that you, the reader, have an understanding of these models and/or concepts because they constitute a central conversation piece throughout this thesis.

1.5 A note on confidentiality

To ensure participants' identities are not discovered, I take the following precautions: I do not disclose the exact geographical location in which this research was conducted; I do not disclose the names of the medical facilities and cultural centers where I collected data; I use pseudonyms to replace participants' real names; and I do not reveal the specific cultural groups to which participants have membership (e.g. French-Canadian, sixth generation Japanese Canadian, Cree, Salish, etc.) other than to allocate them into the political collectivities "Aboriginal" and "non-Aboriginal". Given that I will be providing each participant with a copy of this thesis, as well as other health care professionals who have expressed interest in reading it, it is paramount that participants' identities remain anonymous.

I am aware that one of these precautions may be potentially essentializing—the precaution pertaining to participants' cultural memberships—but, again, I feel that it is a

¹⁶ According to Lessa (2006), "discourse", as conceptualized by Michel Foucault (1972), may be summarize as "systems of thoughts composed of ideas, attitudes, courses of action, beliefs and practices that systematically construct the subjects and the worlds of which they speak" (p. 285), and "discourse analysis", referring to Foucault's (1972) examination of discourses, as the analysis of "the construction of current truths, how they are maintained and what power relations they carry with them" (p. 285).

necessary precaution to maintain their anonymity. In my experience, Aboriginal people have introduced themselves to me by name *and* cultural affiliation, e.g., “My name is Robert and I am a James Bay Cree First Nations” or “My name is Terry; my father is Red River Métis; my mother is Interior Salish; and I am a registered member of the Shushwap band”. This, in my experience, is not a custom that I have observed among non-Aboriginal Canadians. For example, I have yet to meet a non-Aboriginal Canadian who introduces him or herself by name *and* cultural affiliation, e.g., “My name is Jack; I am first generation Canadian; my mother is German and my father is Greek”. Such being the case, that I do not reveal participants’ specific cultural affiliations is primarily meant to protect the identities of the Aboriginal participants in this study whose specific cultural memberships may be just as significant as their real names. However, whenever possible, I articulate the cultural groups to which the Aboriginal scholars and anthropologists have membership because, unlike the Aboriginal participants in this study, I need not conceal their identities. Notably, I do not articulate the cultural groups to which non-Aboriginal scholars and anthropologists belong because, again, in my experience, this variable does not strike me as one into which most non-Aboriginal scholars and anthropologists inscribe meaning.

Chapter Two

Methods

2.1 Place

Multi-sited Ethnography: Developments in the field of multi-sited ethnography are largely attributed to the work of anthropologist George Marcus who suggests that this genre of research entails the pursuit of connections, associations, and putative relationships (1995: 81). The kind of knowledge produced as a result of this work, he argues, varies in both intensity and quality (p. 84). Marcus identifies the following six trends in multi-sited ethnography: follow the people; follow the thing; follow the metaphor; follow the plot, story, or allegory; follow the life or biography; and follow the conflict. This thesis exemplifies what Marcus calls “follow the conflict”. In particular, this thesis follows the conflict of integration—the integration of Aboriginal healing traditions into urban medical facilities—by tracking the perspectives of individuals who: 1) work in medical facilities; 2) practice Aboriginal healing traditions; and 3) use Aboriginal healing traditions.

Geographic Location: For reasons of confidentiality, I do not reveal the name of the exact geographic location in which this study was conducted. However, I feel that it is safe to say data were collected in a western Canadian city from various sites, including: medical facilities (where I interviewed health administrators); restaurants and cafés (where I conversed with health administrators, practitioners of AHT, and users of AHT); my home (where I conversed with health administrators and practitioners of AHT in person and over the phone); and a series of what Native American anthropologist Reyna Ramirez (2007) calls *native hubs*. According to Ramirez (2007), a member of the

Winnebago tribe of Nebraska, native hubs are “gathering sites”, such as powwows, sweat lodges, cultural events, and political activities, as well as virtual activities, such as emailing, reading tribal newspapers, and tapping into internet-based discourse (p. 3). Ramirez describes how the concept of a hub was first conveyed to her by Laverne Roberts, a founder of American Indian Alliance: “Like a hub on a wheel, Roberts argued, urban Indians occupy the center, connected to their tribal communities by social networks represented by the wheel’s spokes” (p. 2). Ramirez further explains: “The city acts as a collecting center, a hub of Indian peoples’ new ideas, information, culture, community, and imagination that when shared back ‘home’ on the reservation can impact thousands of Native Americans” (p. 2). The concept of the hub, in effect, “suggests how landless Native Americans maintain a sense of connection to their tribal homeland in urban spaces through participation in cultural circuits” (p. 3).

The native hubs I frequented to gather information included: an Aboriginal cultural center, an Aboriginal addictions society, and an Aboriginal outreach facility. Ramirez’s definition of the hub encompasses the kinds of activities I observed and participated in at these sites, including: sweat lodges, powwow dancing practices, powwows, healing and talking circles, and other cultural events. Isabelle, the Executive Director of the Aboriginal cultural center,¹⁷ described this hub as the heart of the urban Aboriginal community and as a training ground for both Aboriginal and non-Aboriginals alike:

There’s a large number of these people [urban as well as reserve-based Aboriginal people] that find that this is a place to come and meet family from out of town and what not, so it’s the heart of the community and it’s also, and has been since the inception of [these types of cultural centers], a training ground for our young people: This is where they get their volunteering opportunities, this is where they

¹⁷ Isabelle is also a board member of a walk-in clinic and has been for the past twelve years.

get their first job, their summer jobs as students, and for some, this is where they have chosen to come and find employment and then through that employment recognize what's needed in the community and further their education; so it's also a place of showing what the opportunities are out there. We are also an educational institution for non-Aboriginal agencies and organizations. We get a lot of people coming and having their meetings here and asking us to present and so we get the graduating teachers coming here for a full day.

In addition to these services, I would add, this hub functions as a gathering space for employment networking. The first time I visited this hub, I wandered up and down the halls trying to “take in” the surroundings. There, I saw two young Aboriginal men (about 20 years old) standing before a well-postered poster board, leafing through the jumble of papers. I overheard the slightly younger-looking man say he had just moved into the city from his reserve to look for work. The other man gave him some possible leads: He said he had a friend who could get him a job painting the hulls of boats. He thought he might also have a chance working in construction. The younger looking man was so happy, and so thankful to have made this connection. I think it is safe to say, hubs such as this also serve as gathering spaces for emotional support.

2.2 Contacts

My endeavour to get in touch with health administrators was facilitated by: 1) friends of mine who work within the health care system; and 2) Internet research. Several months prior to commencing fieldwork I contacted a family friend: a professor of medicine at a western Canadian university. My request was straightforward: “I would like to talk to health administrators about the concept of bringing Aboriginal healing traditions into urban medical facilities: Can you please point me to someone who knows about that kind of thing?” This quick and easy consultation turned up a number of contacts, including non-Aboriginal and Aboriginal health administrators, AHT

practitioners, and users of AHT. The Internet proved to be another effective tool for locating health administrators and other health professionals whose jobs entail administrative responsibilities, such as social workers, community health workers, and physicians.

2.3 Gathering data

Interviews: To explore the possibility of bringing Aboriginal healing traditions into urban medical facilities I conducted a total of twelve semi-structured interviews with Aboriginal and non-Aboriginal health administrators (ten); an AHT practitioner (one); and a user of AHT (one). All of the interviews were recorded using a digital recorder and transcribed by me onto my laptop computer. I asked health administrators to share their thoughts on the following issues: a) the concept of cultural competence and other health care models; b) patients' use of or interest in using Aboriginal healing traditions; c) the use of Aboriginal healing traditions within urban medical facilities; and d) sensorial dimensions of health care and sensory-friendly medical facilities. I asked the AHT practitioner, Smiling Stone, to share his thoughts on the following issues: a) becoming an AHT practitioner; b) the use of Aboriginal healing traditions within medical and integrative medical facilities; c) the use of Aboriginal healing traditions by non-Aboriginal people; and d) the sensorial dimensions of Aboriginal healing traditions. I asked the user of AHT, Ellen, to share her thoughts on the following issues: a) the use of Aboriginal healing traditions in urban medical facilities; and b) sensorial dimensions of Aboriginal healing traditions and biomedicine.¹⁸

¹⁸ Please see Appendix A for the list of interview questions for AHT practitioners and Appendix B for the list of interview questions for health administrators.

Conversations - Telephone and In Person: Conversations were precursory to interviewing in four cases. For example, upon locating one of my conversation partners on-line and subsequently introducing myself via email, we arranged to meet in person to discuss my research aspirations. Meeting me in person was an important step for building trust, one that facilitated subsequent meetings and eventually an interview. Conversations were relatively open-ended, inspired by my research question but certainly not limited to it, and allowed both the participants and me to explore ideas and issues at a natural progression. I am grateful for this flexible process for it proved to be an effective means for clarifying and/or modifying my program of research. In total, eleven conversations were held. Eight of the eleven conversations were held in person and the other three were held over the phone.

All of the in person conversations were with Aboriginal persons, although five of them were with one Aboriginal person in particular: A medicine man (Blackbird) who was not receptive to interviewing. My efforts to engage him in an interview were consistently declined in a subtle, indirect manner. This was not surprising to me: I knew he held experiential knowledge in high esteem, higher than mental knowledge, and that he was not enthusiastic about sharing his expertise for academic purposes. Jean-Guy Goulet's book *Ways of Knowing: Experience, Knowledge and Power among the Dene Tha* (1998) speaks to my situation. In Dene society "true" knowledge is personal knowledge and is acquired by experience not instruction. For this reason, Goulet remarks, "it is clear that interviews are a poor means of investigation among the Dene" (p. 54). Goulet states that Native Americans in general are not inclined to objectify knowledge through instruction (p. 30) and, although I am not in a position to make the same claim—

as I have not conducted extensive research with Aboriginal people—his observation does resonate with my experience.

I took notes by hand during all telephone conversations and typed them onto my laptop computer within a couple of days. I took notes during three of the eight in person conversations, which I continued to bolster after the conversations had ended. During the other five conversations, I inscribed notes as soon as possible thereafter.

Participant Observation - Healing and Talking Circles (Aboriginal Healing Traditions): Between May 16 and September 27, 2007, I participated in healing and talking circles at various sites, including: an Aboriginal cultural center; an Aboriginal addictions society; and an Aboriginal outreach facility. In my endeavour to gain entrance into the circles, I introduced myself to the directors and/or circle leaders at each site as a master's student in anthropology. I was equally open in communicating my research to the circles' attendees when introducing myself. I was welcomed on every occasion. In fact, several Aboriginal people made a point of telling me how important it was for me to experience the circles for myself: to go beyond "book-learning". I know they respected my attempt to do this.

On most days, healing and talking circles comprised between ten and thirty individuals. Each took place within rooms where Aboriginal paintings, carvings, and sculptures adorned the walls and counter tops, and dream catchers and bead sashes hung from the ceilings. Upon entering these rooms, my gaze would always catch upon the climbing stream of smoke rising from the smudge pot; the sight was enough to measure my pace as I walked towards my seat in the circle, to slow down my breathing, and to soften my gaze; as if my whole being was trying to match the steady sense of peace and

warmth it exuded. Indeed, my experience being in these rooms was spiritually and somatically enriching: My physical body was affected by the kind of energy that is manifest in people who sit quieted, surrounded by organic materials and art work, watching and breathing the rising, swirling smoke of burning sage or cedar. Listening to people's personal stories and thoughts impacted my emotional state and I was equally moved upon sharing my own. My mental state was also affected simply by paying attention to protocol; that is, watching and listening to what people said and did as they interacted with one another, as they cleansed themselves with smoke, and as they took turns speaking.

While participating in the circles I never once felt comfortable jotting notes. Certainly, I would like to have captured the circles' sequence of events in writing but I felt that note-taking was inappropriate under the circumstances. When people come together for the purpose of listening to each others' personal stories and thoughts, I feel that it is: 1) impolite to draw one's attention away from the speaker to take notes; and 2) inconsiderate to those who are listening wholeheartedly: Note-taking can be noisy and very distracting. As an attendee myself, I was not inclined to jot notes because I wanted to experience the circles fully without periodically disconnecting from the group. More profoundly, I felt that note-taking might incur feelings of betrayal: There was an unspoken rule that what was said in the room would stay in the room. Such being the case, I recorded all fieldnotes pertaining to healing and talking circles in the privacy of my own home, usually one to three hours thereafter.

Participant Observation - Sweat Lodge (An Aboriginal Healing Tradition): In the month of July (2007) I attended a sweat lodge associated with an Aboriginal addictions

society. My invitation into the sweat was preceded by an hour-long conversation with the society's executive director, Leonard, who wanted to get a sense of my research aims prior to connecting me with Peggy, the society's female sweat lodge Pourer.¹⁹ I sent Peggy an email that same day and she invited me to join the sweat that was scheduled for the following week. She asked me to bring a token of tobacco for Ben, the Fire Keeper, a young Aboriginal man who would be in charge of building the fire used to heat the rocks for the sweat lodge. He would also be the one to pass the hot rocks from the fire into the lodge at the onset of each prayer round (of which there were four.) Peggy also asked me to wear a long nightgown with full-length sleeves and to ensure that I was not on my moon time (menstrual flow). According to Peggy, a woman on her moon time does not need to partake in a sweat lodge because her body is already engaged in a cleanse of sorts.

In addition to Peggy and myself, two other women participated in the sweat: Rita, an Aboriginal woman in her early thirties, and Mona, a non-Aboriginal woman in her fifties. This was a Woman's Sweat therefore there were no male participants. The sweat was scheduled to begin at 11:00 am but, following Peggy's advice, we all arrived at the house (the Aboriginal addictions society) at about 10:30 am so that we would have enough time to change into our gowns. Sure enough, I managed to forget the gown I bought especially for the event, so Peggy lent me one. It was dark blue and too long—so long that it dragged on the ground as I walked and I stepped on it repeatedly as we made our way down to the sweat lodge.

¹⁹ The Pourer is the designated sweat lodge leader. The name derives from the act of pouring water over hot stones. The pourer is not the only sweat lodge participant to pour water over the rocks; other participants do this too. However, he or she is in charge of directing the pourings and the prayers. The Pourer is not necessarily an AHT practitioner.

Situated about fifty meters from the house, the lodge was nestled among evergreens, towering birch trees, and other shrubs. A small creek trickled nearby. The sky was a pale blue and dotted with bright white clouds. The air was coolish and a slight breeze intermittently swept through the trees.

No more than a meter from the lodge roared a fire the size of a vending machine. There stood Ben, the Fire Keeper, tending to a pile of glowing pink-red rocks as big as cantaloupes. Ben pushed them a bit with a pitchfork sending small yellow sparks whirling upwards. The rocks were so hot, they looked almost translucent; I swear I could see straight through them. Standing there before the lodge in my gown, among the trees, among new faces, I felt a little nervous and, actually, a little embarrassed to be wearing an oversized nightgown. Peggy commented on Ben's efforts: She thanked him for volunteering his time, and she thanked him for his kindness and for his hard work. Ben smiled shyly, without even a glance in our direction.

The lodge was a round shaped structure constructed with cedar and birch boughs, insulated with thin blankets, and topped with a black plastic tarp. Before heading in, Peggy passed around an abalone shell in which a tablespoon of sage smoldered and smoked, and she asked us to smudge ourselves: to waft the smoke over our eyes, ears, nose, mouth, and hearts to purify our bodies. Afterwards, Peggy asked us to walk clockwise around a bowl of blueberries, a bowl of canned fish, and a pair of antlers that she had placed on the ground between the fire and the lodge: During the sweat, Peggy would use the antlers to manipulate (move around) the hot rocks within the lodge, and the berries and fish were there to eat; to replenish our energy after the sweat.

Once inside the lodge, the soil floor beneath my thin Styrofoam sitting mat was hard and icy cold. With just enough light streaming through the open doorway, I noticed half a dozen small pouches of tobacco strung from the ceiling; prayer offerings that had been hung by sweat lodge participants over the years.

Before shutting the door, Ben handed in the following items: seven hot rocks, which he plunked (using a pitch fork) onto a shallow bed of pebbles in the center of the lodge; a white plastic bucket filled with water; and four leather drums, one for each of us. “Grandfather coming in”, he would say, each time he passed in a rock. “Bringing in Life”, he said, as he passed in the bucket of water, and “Bringing in the heartbeats”, he would say, as he passed in the drums. When he finally shut the door, I was shocked and momentarily fearful of the darkness that encompassed us. The luminous stones dimmed quickly.

During the first (and only the first) round, Peggy asked us to pick up a hand drum and to hold it over the hot stones; she said that it would make for a better, deeper sound. Peggy initiated a slow beat on her drum and then the rest of us joined in (beating on ours). It was also during the first round that Peggy asked us to pray for Male Energy (grandfathers, fathers, brothers, sons, and partners). In the second round, she asked us to pray for Female Energy (grandmothers, mothers, sisters, partners). In the third round, she asked us to pray for children (all children), and in the fourth round, she asked us to pray for ourselves. Peggy initiated the prayers at the beginning of each round, and then the rest of us took turns in a clockwise direction: first Rita, then me, and finally Mona. Before each one of us prayed, we placed bits of sage and tobacco onto the hot rocks saying, “hello Grandmother, hello Grandfather”. The smoke produced as a result of this act

would carry our prayers up to the spirit world. Immediately following this act, we splashed the stones with water from the white plastic bucket, and then we began to pray, either out loud or in silence. When it was my turn to pray (on the first round), sitting cross-legged on mat, my body slipped into a steady rocking motion. Strangely, I did not realize that I was swaying back and forth until about ten seconds into my sharing time, and for some reason, I did not want to stop; somehow the motion made it easier for me to speak out loud. I spoke for about four minutes or so, and when I was finished, I said “all my relations”; this is how the others knew that I had said everything that I needed to say for the time being. Funnily, I hardly rocked at all during the second, third, and forth rounds, and indeed, it was hard for me to speak; I felt so grounded in my body that I could barely bring myself to think with words.

When Mona spoke (in English), her words were smooth and measured like poetry: She enunciated each word with clarity and rhythm. When Rita spoke (in English) she trembled and cried loudly. She was holding onto a lot of pain for friends in downtrodden places—Aboriginal women who live and work on the streets; Aboriginal women whose everyday lives are dominated by fear, physical abuse, and drug-addiction. When Peggy spoke (in English), she mumbled and cried only slightly. Although I cannot say for certain, it sounded as though she was saying “thank you Creator” before and after each phrase. This was a pattern I had observed in other contexts, during healing and talking ceremonies (e.g. “thank you Creator for giving me this life Creator”). I did, however, grasp one of Peggy’s phrases in its entirety, and it is one that I will not forget: “don’t ask for less burdens; ask for a stronger back”.

Temperature wise, the lodge was not too hot (for me at least) during the first and second rounds, but rounds three and four were almost unbearable. I sprinkled water from the bucket onto my head and breathed deeply to sustain myself.

Stepping out of the lodge, two hours later, I felt a little dizzy. Thankfully, there were fish and berries for me to eat. The bright white clouds that spotted the sky at the onset of the sweat had diffused into a sprawling grey haze. Only then did I notice the bright yellow bulldozer parked through the trees on the neighboring property. Only then did I hear the steady stream of cars as they rolled along the pavement nearby. Only then did I notice the high-rise condominiums that shot into the sky a few blocks down; I wondered if any of its inhabitants had been watching; I wondered why I was oblivious to these technological landmarks before the sweat, and so acutely aware of them afterwards. Standing there, in my damp-wet gown, I wondered how a sweat lodge ceremony like the one I had just participated in could be carried out within urban medical facilities: It would not be easy.

Participant Observation - Powwow Dancing Practice and Potluck Events:

Between May 16th and July 03rd I spent a total of five evenings at an Aboriginal cultural center where I participated in either powwow dancing practices (three) or pot luck events (two). My endeavour to take part in these activities was motivated by my desire to meet urban-based Aboriginal people and to observe and experience Aboriginal cultural activities. Activities were held in a gymnasium where between fifteen and seventy-five chairs were set up, depending on the size of the crowd. On powwow practice evenings I spent about eighty-five percent of the time watching young men, women, and children dancing to live drumming and singing. I danced about fifteen percent of the time. On

potluck evenings I spent about ninety-five percent of the time watching the crowd and sitting in my chair eating (usually fish and rice or pasta).

Participant Observation - Powwow: I attended one outdoor powwow during the month of August (2007). Mainly, I arrived, wondered around, bought a couple of items (e.g. an herbal remedy and some jewelry), said hello to some people I recognized from the Aboriginal cultural center, and after about forty-five minutes I left. The crowd comprised approximately 150 people.

Participant Observation - Reconciliation Ceremony: One autumn morning, a couple of months after “completing” my fieldwork, I came upon a reconciliation ceremony while jogging. Alongside a large body of water, fifty people stood gathered around a blazing fire. It was pouring with rain. There was drumming, singing, candle lighting, poetry being read, and sweetgrass being passed around. A local First Nations band had organized this event for the purpose of bringing attention to the concept of reconciliation in general.

2.4 Analysis of data

Interpretive Description: Interview transcripts and fieldnotes were analyzed inductively using interpretive description. According to health care researchers Thorne, Reimer, Kirkham & O’Flynn-Magee (2004), interpretive description aims to produce a descriptive body of themes or patterns that commonly characterize a given clinical phenomenon while accounting for variations within them (p. 6). Its product is thus not a body of new truths, but the establishment of tentative truth claims (p. 7). Epistemological keystones include: 1) reality is ultimately subjective; 2) the inquirer and the object of inquiry influence one another; and 3) theory must be grounded in the data (p. 5).

Phases of Analysis: Data analysis took shape in three distinct phases. **Phase one** involved: 1) re-reading all of my interview transcripts and fieldnotes; 2) whittling paragraphs and phrases into thematic statements; 3) numbering each thematic statement with the particular number and color I had assigned to its interlocutor; 4) looking for common themes and/or variations of the same theme between data sets; 5) and fixing all thematic statements under broader, more general themes. **Phase two** involved: 1) constructing a mis-a-plat chart upon which all of the thematic statements were displayed and organized in an umbrella-like structure; major themes atop the page and sub themes trickling beneath. **Phase three** involved: 1) observing who said what; and 2) theorizing why participants responded as they did while keeping in mind that their views may have been influenced by factors such as age, gender, years of experience, and ethnicity.

2.5 Motivation for research

My decision to pursue this topic of research stems from my experience working in an integrative medical facility as well as my experience working as a research interviewer in cancer control research, a branch of epidemiology. Whereas Aboriginal healing traditions are not entirely absent from these contexts, I am intrigued by the relative absence of AHT practitioners. For example, traditions such as the medicine wheel, saging, and talking circles are employed in a variety of medical contexts without the involvement of AHT practitioners. By conducting this research, it is not my intention to “prove” that Aboriginal healing traditions “work”—that is, that Aboriginal healing traditions are efficacious. Nor is it my intention to provide a detailed description of Aboriginal healing traditions. Rather, I seek to show that the use of Aboriginal healing traditions within urban medical facilities is a task far more complex than “integrative

medicine”; it is very much a matter of cultural integration and it is thoroughly political. Moreover, I have a deep respect for Aboriginal peoples and worldviews and believe that there should be a place for Aboriginal healing traditions within Canada’s health care system in some capacity.

<p style="text-align: center;">Chapter Three Literature Review: History and Power in Health Care Scholarship</p>

3.1 Integration -- Easier said than done

As stated in Chapter 1, this thesis seeks to explore the potential for Aboriginal healing traditions to be formally integrated into urban medical facilities. In spite of health care scholars' increasing suggestions to integrate the two systems, how such an endeavour ought to be accomplished is not discussed. For example, there is no discussion of which health care model or models should be used to carry out the task. Does culturally competent health care as a model work just as well as the model of patient-centered care? And what about cultural safety as a model—might it be a better choice given that it was developed by Indigenous nursing researchers? Furthermore, there is no mention as to how drumming, singing, smudging, and sweats are to be accommodated in hospitals, for example, where noise control, air quality, and rigorous cleanliness take precedence.

As it turns out, logistical guidelines for integrating the two systems have been little discussed. Nursing researcher Jean-Ann Cantore (2007) provides some useful tips. For example, she describes an American hospital where medicine men and women are able to perform healing rituals because they have access to a room set aside for that purpose. Beyond this example, however, research on the topic is largely devoted to showing how difficult integration would be due to historical/political, practical, and philosophical challenges. Indeed, the use of Aboriginal healing traditions within urban medical facilities is presented as a “problem” for a number of reasons.

The first reason, according to anthropological and sociological research on the topic, relates to the historical and systematic oppression of Aboriginal peoples. For example, given that Aboriginal spirituality and healing ceremonies were prohibited in recent Canadian history, it is a growing concern among Aboriginal Elders that their healing and curing traditions might again be controlled and/or seized (appropriated) by non-Aboriginal society. The second reason, offered mainly by health care researchers on the topic, relates to practical and philosophical challenges of the systems themselves. To cite a philosophical example: according to most, if not all, Aboriginal worldviews, an individual's health extends to include the health of the plants, animals, and spirit world (see further Adelson, 2005). In Western medicine, by contrast, an individual's health is viewed in terms of his or her personal physiology. There are also a number of practical incongruities between the two systems, such as the kind and quality of environments in which care and/or treatments are administered.

I examine these challenges, among others, in section 3.2 and, subsequently, criticize the ways in which researchers portray the two systems in essentialist—and sometimes erroneous—terms, and fail to address the ways in which ideologies within health care culture, such as the credo “equality of care”, might pose problems. I further argue that the biomedical paradigm—the medical paradigm that is *the* status quo—may significantly hinder the process.

3.2 Practical and philosophical challenges

In her essay titled “Aboriginal Traditional Medicine: Where does it fit?” nursing researcher Angeline Dee Lentendre (2002: 81-85) discusses the conflicts of integrating

Aboriginal healing traditions with biomedicine. Below is a summary of Lentendre's main points:

Delivery of care: Traditional Aboriginal medicine is delivered in less formal environments, typically out of doors where medicine men can more readily tap into the Creator's healing and curing powers. Over the course of the patients' sickness episode, medicine men and women themselves deliver healing methodologies. Biomedicine, on the other hand, is typically delivered in confined environments and physicians are subject to a health care delivery system that does not facilitate lengthy patient visits. In the event that patients do receive biomedical treatments or procedures, nurses and other specialists, are typically the ones to administer them, not physicians.

Philosophical incongruities: The self, according to Aboriginal philosophy, comprises physical, emotional, mental, and spiritual dimensions and is sustained by the environment and the spirit world. To have balance and harmony, the self must tend to each of its four dimensions as well as all of the forces of nature. Biomedicine, in contrast, treats the various dimensions of self in isolation from one another. For example, body and mind are generally thought to be separate functions and are treated in separate areas of medicine, e.g. internal medicine for the body and mental health for the mind. Spiritual dimensions of the self are altogether ignored.

Power differential: Lentendre observes that the most discernable difference between traditional medicine and biomedicine is the nature of the patient-healer relationship. In traditional Aboriginal medicine, both the healer and the patient are active players in the healing and curing process, however the source of healing and curing energy is credited to the Creator. In biomedicine, physicians are credited for their

patients' health and illness outcomes, moreover physicians, and physicians alone, are credited with the power to heal and cure.

In their article titled, "Native Americans: Traditional Healing", nursing researchers Broome & Broome (2007: 163) chart out a set of binary oppositions between the two systems, paraphrased here:

1) Western medicine focuses on pathology and curing diseases whereas Native American medicine focuses on health and healing the person and community; 2) Western medicine is reductionist: diseases are biological and treatment should produce measurable outcomes. Native American medicine is complex: Diseases do not have a simple explanation and outcomes are not always measurable; 3) Western medicine is adversarial: it asks, "How can I destroy the disease?" Native American medicine is teleological: it questions, "What can the disease teach the patient? Is there a message or story in the disease?"; 4) Western medicine investigates disease with a divide-and-conquer strategy whereas Native American medicine looks at the big picture: the causes and effects of disease in the physical, emotional, environmental, social, and spiritual realms; 5) In Western medicine, intellect is primary and medical practice is based on scientific theory. Native American medicine is primarily based on intuition and healing is based on spiritual truths learned from nature, elders, and spiritual vision; 6) In Western medicine the physician is the authority whereas in Native American medicine, he or she is a health counselor and advisor; 7) Western medicine fosters dependence on medication, technology, etc. whereas Native American medicine empowers patients with confidence, awareness, and tools to help them take charge of their own health; 9) Western medicine's inquiry into patients' health histories asks, "Did your mother have cancer?". Native

American medicine's inquiry asks, "Are the salmon in your rivers ill?"; 10) Western medicine should result in rapid cure of management of disease and (for once) the same can be said for Native American medical interventions.

Lentendre and Broome & Broome's descriptions are useful in that they bring to light prominent practical and philosophical incongruities between the two systems—something to bear in mind if or when integration takes place. However, they are problematic in more ways than one. For example, the way in which Broome & Broome are fixated upon Native American medicine as healing-centered and biomedicine as curing-centered perpetuates the all too common assumption that Aboriginal medicine is only concerned with healing and biomedicine with curing when in fact both system encompass elements of each. My views on this matter are consistent with Waldram's (2000) when he writes, "it is erroneous to assume that biomedicine only "cures disease" or that traditional medicine only "heals illness", or that they are completely distinct phenomena" (p. 605). Waldram is also critical of the commonly accepted meanings attributed to the terms "curing" and "healing":

It has become de rigueur to accept that *curing* refers to a primarily biological process that emphasizes the removal of pathology or the repairing of physiological malfunctions, that is, disease, while *healing* refers to a broader psychosocial process of repairing the affective, social, and spiritual dimensions of ill health or illness (p. 604 emphasis in original).

The problem with accepting these terms, Waldram argues, is that they do not necessarily represent traditional Aboriginal notions of "curing" and "healing". Following Csordas (1983), Waldram (2000) argues that curing, in the context of religious or symbolic healing, is conceptualized as a shift in the patients' perception of his or her illness more so than symptom removal (p. 615).

It is also important to note that both Lentendre and Broome & Broome attribute the problem of integration to philosophical and practical components *of the systems themselves* and fail to acknowledge that health care providers' attitudes, beliefs, and assumptions might also pose problems. For example, there is no mention that health care providers who perceive Aboriginal people as being drunk, drug-addicted, and violent might not be inclined to assist an Aboriginal patient in locating an Elder (see further Browne, 2005). To give another example, neither Lentendre nor Broome & Broome explore how attitudes within health care culture, such as the credo "equality of care", might be problematic. Health care providers who adhere to this concept might feel that they have the right to turn down a patient's request to see an Elder because they would not want to favor one patient over another. Also interesting, although Lentendre points out that physicians are credited with the power to heal (as opposed to the Creator) she does not address the possibility that the power of physicians might deter AHT practitioners from wanting to collaborate with them. Finally, I would like to point out that practical and philosophical differences between the two systems do not inhibit individuals from discerning the validity and usefulness of them both. In other words, just because the systems "do not get along", so to speak, does not mean that people cannot pick and choose the parts that work for them.

One of the philosophical incongruities left relatively untouched by Lentendre—and not addressed at all by Broome & Broome—is how each system measures success and/or efficacy. In 1999, the Vancouver/Richmond Health Board put forth a number of recommendations pertaining to Aboriginal health services. At that time, it was stated, "in the community there is general agreement that mainstream systems are not able to deliver

the type of care [Aboriginal] people need”²⁰ (p. 67). Following this, it was suggested that an Aboriginal healing center be implemented, where holistic, culture-based health care programs could be realized in addition to Western ones. The suggestion, however, was not without warning:

It is possible to offer both traditional medicine and western medicine within the same structure. However, great care must be taken to ensure that the generally accepted power of professionals not undermine the intent of a culture-based center (p. 67).

That health care professionals might undermine the intent of a culture-based medical center is a valid concern given that Aboriginal healing traditions are not thought to be efficacious from the vantage point of biomedicine. Part of the problem, I think, is that the efficacy of Aboriginal healing traditions cannot be measured using biomedical and/or scientific standards. Lentendre (2002), for example, writes “western society’s demand for the scientific basis of medical care and the systematic recording of knowledge is in direct opposition to the philosophies of traditional medicine” (p. 84). Along the same lines, in his essay on the efficacy of Aboriginal spirituality, Waldram (2000) argues that our understandings of the efficacy of Indigenous medical systems are affected by biomedical paradigmatic constraints. Compared to the apparently “universal, objective, and empirical biomedicine”, they are viewed as “culturally constructed, subjective, and primarily symbolic” (2000: 604).

That Aboriginal healing traditions are affected by biomedical paradigmatic constraints has important implications. Waldram’s (1997) work on Aboriginal spirituality and symbolic healing in Canadian prisons offers important insight on the matter. In

²⁰ Naomi Adelson made a similar observation in 2005: “We must come to understand that conventional clinical approaches may not fit well with traditional indigenous values or with the realities of contemporary settlement or urban life” (Adelson, 2005: 47).

particular, Waldram argues, “the answer to the question, ‘does Aboriginal spirituality *work*?’ must be situated within the context of how the Elders see inmates’ problems in the first place, and how Aboriginal spirituality deals with them” (p. 214). The challenge, then, I argue, lies not in proving that Aboriginal healing traditions “work” but rather in convincing health care providers that biomedicine is but one of the world’s many culturally-informed medical systems; that Aboriginal healing traditions have their *own* rules and measures of success as defined by their *own* users and practitioners.

Remuneration is yet another philosophical challenge that integration entails. Because traditional Aboriginal philosophies do not support the concept of paying healers for their services, formal pay scales have yet to be developed. Benoit et al.’s (2003) investigation of Aboriginal women’s perception of health care services in Vancouver’s Downtown Eastside, states: “few traditional healers were willing to work in a clinical setting not only because it was located in an urban ghetto, but also because of problems regarding adequate remuneration” (p. 825). Unfortunately, Benoit et al. do not address how the traditions of those AHT practitioners who were willing to work in clinical settings were accommodated. I suspect many of them were not—a reality that is reflected in my interview data in Chapter 6.

3.3 Historical/political challenges

Despite that the suggestion to integrate Aboriginal healing traditions into urban medical facilities is intended to enhance urban-based Aboriginal people’s health care experience, the concept poses a dilemma for those Aboriginal people who wish to protect and keep separate their healing traditions. Given that Aboriginal religion and healing ceremonies were declared illegal in 1883 and have only been legal in Canada since 1951,

distrust of the dominant society is to be expected. In 1883 the federal government passed a law banning potlatch feasts and related ceremonial activities; just one of many measures used to assimilate Aboriginal peoples into mainstream Canadian society. The law was revised in 1884 and 1885, outlawing spirit dancing or "*Tamanawas*", the Salish healing ceremony, as well as certain aspects of the Grass Dance and the Sun Dance. The ban on Aboriginal religion, and subsequent healing ceremonies, was further revised in 1914, 1918, and 1933 (see Waldram 1997: 6-8). Wolfgang Jilek (1973) makes specific reference to the Potlatch law as it appeared in the Statutes of Canada in 1884:

Every Indian or other person who engages in or assists in celebrating the Indian festival known as the 'Potlatch' or in the Indian dance known as the 'Tamanawas' is guilty of a misdemeanor, and shall be liable to imprisonment for a term of not more than six nor less than two months in any gaol or other place of confinement, and any Indian or other person who encourages, either directly or indirectly, an Indian or Indians to get up such a feast or dance, or to celebrate the same, or who shall assist in the celebration of same, is guilty of a like offense, and shall be liable to the same punishment (Section 3, Statutes of Canada, 1884; op. cit. La Violette, 1961: 43 as cited in Jilek 1973: 14).

In Dawn Martin-Hill's (2003)²¹ report on traditional medicine in contemporary contexts, she lists government control over Indigenous medicine as a current and threatening concern among Elders and healers. In particular she writes: "the Elders/healers highlighted the fact that it was in their recent history that these ways were outlawed, and perhaps now, the government is finding another way to control their spirituality, healing, and ceremonies" (p. 28). As previously noted, Benoit et al. (2003) have observed that few healers are willing to work in clinical settings because of remuneration problems. They also state that healers are put off from providing their services due to "government regulation of traditional practices and threat to traditional contents" (p. 824-825). Indeed,

²¹ Dawn Martin-Hill is a Mohawk cultural anthropologist and documentary filmmaker.

the appropriation and/or commodification of traditional medical knowledge poses yet another challenge to integration. In an article titled, "Sweetgrass and Laser Surgery" by Peter Verburg (1994), one of the presidents of the Native Council of Canada is quoted saying that Native Elders are extremely secretive about their healing techniques because they fear business people will patent their herbs (p. 35). Likewise, Martin-Hill (2003) observes:

Intellectual property rights regarding traditional medicine are highly controversial, stemming from the historical and continued exploitation of Indigenous knowledge by Eurocentric prospectors. Today large pharmaceutical companies mine Indigenous knowledge, acquiring patents and profit from it (p. 16).

As noted earlier, few logistical guidelines for the integration of Aboriginal and Western medicine exist. I would like to add that there are equally few guidelines on how to engage practitioners of AHT in the process. Most likely, this situation relates to the problem of remuneration—traditionally, Aboriginal healers did not work for money—as well as the problem of accreditation and/or liability: Unlike physicians, Elders are not insurable. In the context of the appropriation and/or commodification of traditional medicinal knowledge, I would like to point out that the use of Aboriginal healing traditions within urban medical facilities without, at the very least, consulting its practitioners *is* a measure of appropriation (e.g. some clinics offer meditation programs during which sage is burned without the involvement of AHT practitioners). Ashley, one of the non-Aboriginal health administrators who helped to inform this study, explained this occurrence to me during a telephone conversation. According to Ashley, medical facilities where "white" health care practitioners employ Aboriginal healing traditions "echoes hollow"; it is just another

way of perpetuating the already racist system—another way to show that we (the dominant society) have conquered them (Aboriginal people).

3.4 Up for the challenge?

The efficacy of Aboriginal healing traditions, distrust of the dominant society, practical and philosophical incongruities, remuneration, liability, and the appropriation and/or commodification of traditional medicinal knowledge—is there such a thing as a health care model that is capable of absorbing this collection of challenges?

This section provides an overview of those health care models that are most relevant to this area of study, including: culturally competent health care; patient-centered care; and cultural safety.

3.4.1 Culturally Competent Health Care

Given that the task of bringing Aboriginal healing traditions into urban medical facilities is a culture-related endeavour it seems only logical to investigate the potential for “cultural competence” or culturally competent health care to facilitate the process. By and large, this concept is founded upon the belief that cultural differences impede minority populations from accessing biomedical care (Shaw, 2005). To rectify this—that is, to ensure that biomedical care is administered effectively and efficiently—health care providers are advised to learn as much culture-related information as they can about the patients they serve. According to medical scholars Betancourt, Green, Carrillo, & Park (2005), “the goal of cultural competence is to create a healthcare system and workforce that are capable of delivering the highest quality of care to every patient regardless of race, ethnicity, culture, or language proficiency” (p. 499). Similarly, anthropologist-

psychiatrist Arthur Kleinman (2004) observes that the concept aims to bestow health care providers with “knowledge and skills to address ‘cross-cultural’ challenges in clinical encounters”(p. 953). Medical anthropologist Susan Shaw (2005) has also pointed out that the concept is being widely adopted by medical schools and clinics where cultural information is disseminated through workshops, programs, and classes.

Culturally competent health care has indeed influenced the ways in which health care providers endeavour to care for Aboriginal patients. Keltner²², Kelly, & Smith (2004), for example, suggest that Native American nurses have the potential to be leaders in reducing Native American health inequities by educating other health professionals on what they know about Native American cultures. Similarly, Native American nursing scholars Roxanne Struthers²³ & Sandra Littlejohn²⁴ (1999) propose, “themes identified by Native American nurses can provide a vehicle for care delivery innovation” (p. 135). The following seven themes were brought to Struthers & Littlejohn’s attention by other Native American nurses: caring, traditions, respect, connection, holism, trust, and spirituality (p. 133-134). According to Struthers & Littlejohn, nurses who recollect and draw upon these themes when working with Native American patients will thus be in a position to minimize cross-cultural misunderstandings. Along the same lines, Sanchez,²⁵ Plawecki, & Plawecki’s (1996) model of care is oriented towards gathering information about Native American health beliefs and practices that will in turn assist nurses in their endeavour to be culturally competent. According to them, “cultural ignorance can be

²² Bette Keltner is Cherokee First Nations.

²³ Roxanne Struthers is Red Lake Ojibway First Nations from Minnesota.

²⁴ Sandra Littlejohn is Dakota First Nations.

profoundly detrimental to the interactions between the health care provider and the client” (p. 296) and “understanding the Native American cultural perspective will allow the nurse to facilitate the acceptance and delivery of holistic health” (p. 297). Much like Sanchez et al.’s approach, Buehler’s (1993) culturologic assessment strives to gain information about Native American cultural perspectives and recommends that nurses ask Native American patients questions such as “tell me what I need to know about your culture in order to give you good nursing care” (as cited in Baker, Daigle, Biro, & Roe, 2000: 22).

The very premise of cultural competence—that health care providers can and should be “competent” about minority cultures—is in my opinion both aggressive and condescending. It is aggressive, I argue, because it treats cultural knowledge as something that can be “stood upon” (understood); something that can be “mastered”; something that can be “comprehended” (a word whose etymology is literally “to grasp” or “to seize”) to ensure biomedical care is delivered efficiently and effectively. It is condescending, as such, because it implies that minority patients must be “saved” from their culture, for it is *their* culture that is stopping them from accessing biomedical care, and it is *their* culture that aggravates poor patient-provider interactions. In this way, then, cultural competence is inherently one-dimensional for it entails the flow of cultural information to health care providers from patients and other cultural resources but not the reverse. For example, the concept does not seek to educate minority patients—in fact, *any* patients—on the culture of biomedicine and/or health care. Moreover, the notion that cultural competence has the capacity to smoothen patient-provider relations is misleading for it fails to recognize the systematic and/or societal pervasiveness of the problem. Not

surprisingly, nursing and medical scholars increasingly scrutinize the concept (e.g. Baker et al., 2000; Browne, 2005).

According to Browne (2005), problems arise “when health-care providers are taught to watch for particular cultural traits or cultural differences” (p. 65). The reason for this, Browne argues, is because cultural differences necessarily counterpose cultural norms. In effect, culturally competent health care fosters antagonistic rather than supportive patient-provider relations. Likewise, medical scholars Carpenter-Song, Nordquest-Schwalli, & Longhofer (2007) critique the detriments of the concept. Drawing upon anthropological discourse, they argue that models of cultural competence are problematic because “they present culture as static; treat culture as a variable; do not acknowledge the diversity within groups; may inadvertently place blame on a patient’s culture; often emphasize cultural difference, thereby obscuring structural power imbalances; and finally, fail to recognize biomedicine as a cultural system itself” (p. 1363). Moreover, Carpenter-Song et al. argue, “an encyclopedic knowledge of the world’s cultures and their specific systems of knowledge regarding health and illness is not a requirement for the provision of culturally appropriate care...we recommend that clinicians remain open and willing to seek clarification when presented with unusual or unfamiliar complaints” (p. 1365). After all, they argue, “clinicians are experts in biomedicine; patients are experts in their own experience of distress” (p. 1365). In other words, Carpenter-Song et al. are saying that cultural competence, *as a component of medical expertise*, is both unrealistic and unnecessary. Kleinman (2006) makes a similar point when he writes, “one of the major problems with the idea of cultural competency is that it suggests culture can be reduced to a technical skill for which clinicians can be

trained to develop expertise”. However, unlike Carpenter-Song et al., Kleinman seeks to build upon the concept rather than eschew it and in fact promotes the notion “physician as ethnographer”. In particular, Kleinman advocates for an explanatory model of care—a culturally competent health care model of sorts—devised by Kleinman himself. Kleinman describes the approach as one that prompts clinicians to “set their expert knowledge alongside (not over and above) the patient’s own explanation and viewpoint” (p. 1674). Health care providers will be in a position to do this, Kleinman argues, so long as they ask patients the following questions:

- What do you call this problem?
- What do you believe is the cause of this problem?
- What course do you expect it to take? How serious is it?
- What do you think this problem does inside your body?
- How does it affect your body and your mind?
- What do you most fear about this condition?
- What do you most fear about the treatment? (p. 1674)

Unlike other models of cultural competency, then, Kleinman’s approach does not seek to inundate health care providers with stereotypical cultural information: It “does not ask, for example, “What do Mexicans call this problem?” it asks, “What do you call this problem?” and thus a direct and immediate appeal is made to the patient as an individual, not as a representative of a group” (p. 1676). As a measure to reduce cross-cultural misunderstandings, Kleinman argues, the explanatory model approach is but an “elective affinity to the patient”, not a technical skill. I would like to note, however, that Kleinman’s approach is still very much one-dimensional for it does not entail that health care providers educate minority patients about the beliefs, norms, and attitudes of health care culture. Moreover, although Kleinman advises health care providers to “set their expert knowledge alongside (not over and above) the patient’s own explanation and

viewpoint”, he fails to comment on the ways in which health care providers’ personal (as opposed to technical) attitudes and beliefs are also “at work”.

Browne (2005) is equally critical of health care initiatives that draw upon culture-specific information, however, her issue with cultural competence is not so much that there are better, more effective ways of making biomedical care accessible to minority populations, but that there are better ways to foster positive patient-provider interactions. In the context of Aboriginal health research, Browne makes a case for an increase in research on the discourses that influence nurses’ perceptions of Aboriginal patients (see also Baker et al., 2000) because, Browne argues, their perceptions of them cannot be discussed outside the context of colonization—a belief that is likewise shared by Naomi Adelson (2005) who writes:

Scholars across all sectors of Aboriginal health studies concur that, despite inadequacies in the health care delivery system and regardless of peoples’ relative access to or use of the biomedical system, the problems are entrenched in the history of relations between Aboriginal peoples and the nation-state (p. 45).

What is important to note about Browne’s argument is that culture-related problems in health care contexts are not limited to language barriers and divergent beliefs about health and illness; they extend beyond the reaches of the clinics and into society at large.

Re-evaluating the purpose and parameters of culturally competent health care is an important step for broadening our understanding of the kinds of culture related challenges that arise in health care contexts. However, I would like to point out that nowhere in the above discussion is cultural competence defined in terms of helping minority patients to access culture related and/or traditional remedies or practices. Quite simply, this is because the integration of such modalities is not what culturally competent

health care is designed to do: Advocating the need to know about sweat lodges is totally different than advocating the need to provide sweat lodge services.

3.4.2 Patient-Centered Care

According to health care scholar Joseph Betancourt (2004), “cultural competence has thus evolved from the making of assumptions about patients on the basis of their background to the implementation of the principle of patient-centered care, including exploration, empathy, and responsiveness to patients’ needs” (p. 953). A radical step away from classical health care delivery, wherein physicians’ needs and preferences are central, patient-centered care focuses first and foremost on the needs and preferences of patients and their families.

Nursing researchers Ponte, Colin, Conway, Grant, & Medeiros (2003) have described the concept as a paradigm unto itself. At its most elaborate, they contend, the concept “should define how patients, families, and providers interact at the individual level, how clinical services are structured, how ambulatory units are designed, how bills are formatted, and how buildings are maintained” (p. 84). In their article titled, “Making patient centered care come alive: Achieving full integration of the patient’s perspective” (2003), Ponte et al. describe how they enact the concept, and recommend the following: first and foremost, patient-centered care must be supported by the board of executives; a framework for teamwork must be in place; a system of councils must be devised; patients and health care providers have to trust and be respectful of one another; and a dedicated group of patients is imperative to sustain the process (p. 84).

As reasonable as these tenets may be, they are not necessarily feasible. Consider, for example, the patient who wishes to burn sage in his or her hospital room. If the board

of executives is under the impression that saging does not have any health benefits there is a good chance this patient will not be able to burn sage. The patient may just as well be out of luck if the hospital where he or she rests has a policy that forbids smoking. In other words, health administrators who support the tenets of patient-centered care may not necessarily support, or be in a position to support, the vast variety of means through which patients would have their needs and desires met. To be explicit, I question whether a truly patient-centered model of care can exist in biomedical contexts given that there are a great many health practices that do not appear to meet to biomedical standards (e.g. spirit cleansing) or are scorned by the biomedical community (e.g. ozone therapy, marijuana).

Furthermore, I am not in accordance with Ponte et al.'s assertion that patient-centered care has paradigmatic potential. In spite of its "patient-centeredness", the concept makes the same assumptions about health and health care delivery as the current paradigm. For example, while the concept recognizes that patients are connected to larger family units, it does not recognize patients' relationships with the natural environment and the spirit world. It does not, as such, incorporate an Aboriginal worldview (see further Adelson, 2005). Also problematic is that the concept makes no attempt to reinstate science as the basis and standard of health care delivery. As noted above, patient-centered care seeks to define how *clinical* services are structured and therefore retains biomedicine as its operational paradigm.

Ponte et al. are cognizant that it is important to establish multi-ethnic councils so as to resolve bias in any one area—an important consideration indeed. The challenge remains, however, in establishing a council of members who are trusting and respectful

of one another. Establishing trusting, respectful relationships among Aboriginal and non-Aboriginal council members is of course not impossible but the process is likely to be impeded by non-Aboriginal council members whose perception of Aboriginal peoples are informed by negative stereotypes (see further Browne, 2005). Further, getting Aboriginal council members to foster trust in non-Aboriginal council members may prove to be difficult given the extent to which Aboriginal people commonly distrust the dominant society. No doubt, a challenge unto itself may be finding an Aboriginal person who is willing to be part of such a council.

Health care scholar Ronald Epstein's (2000) version of patient-centered care is centered on the concept "patient-centered communication", a responsibility primarily designated to physicians. In his commentary on patient-centered care, Epstein articulates key communicative behaviors that physicians should observe, which include: identifying and responding to the patients' ideas and emotions regarding their illness; reaching a common ground about the patients' illness and its treatment; and establishing patient/physician roles (p. 805). For Epstein, getting to know "the patient as a person" is where the process of healing begins. In reference to a study by Stewart, Brown, Donner, et al. (2000) he notes, "when patients perceived the visits to be patient-centered they experienced better recovery, better emotional health and dramatically fewer diagnostic tests and referrals two months later" (p. 806).

Epstein's observation about the benefits of being involved in one's program of care has relevance to discourses on culture as treatment. In her (1993) critical appraisal on the use of culture as treatment, Brady suggests that the only reason why Aboriginal people prefer culture-based methods (e.g. the sweat lodge) to treat substance abuse rather

than “accepted” mainstream treatment services is because they want to be both separate and different from the general public. Obviously, Brady is under the impression that culture-based therapies do not have any health benefits—or perhaps she is simply unaware of them. It appears that she is not familiar with the notion that being involved in one’s program of care is health giving. Regardless, the point I am trying to make is that patient-centered care, *as described by Epstein*, has the potential for facilitating the use of Aboriginal healing traditions within urban medical facilities because it promotes *involvement* as efficacious and therefore takes the pressure off culture based therapies from having to “prove” that they are efficacious. I would also like to point out that Epstein’s notion of patient-centered care has more paradigmatic potential than Ponte et al.’s because it entails that physicians and patients reach a common ground about the patient’s illness and its course of treatment. That is to say, if a patient wants to use the sweat lodge as a means of treatment, then his or her physician would be obliged to consider and negotiate that as an option.

3.4.3 Cultural Safety

Developed in the late 1980’s by Maori nursing scholars, cultural safety aims to foster a nursing practice that recognizes, respects, and nurtures the wellbeing and identities of Indigenous²⁶ peoples (Polaschek, 1998: 454). To achieve this, nurses are encouraged to: recognize the negative stereotypes they may fasten to Indigenous peoples; acknowledge that colonization continues to inform Indigenous peoples situations; be informed that Indigenous health services are inadequate; and be aware that Indigenous peoples are subject to institutionalized racism (Polaschek, 1998). According to

²⁶ Indigenous is the term used in Maori scholarship

Polaschek, these tenets sharply contrast with transcultural nursing practices rooted in multicultural viewpoints. In particular, Polaschek (1998) writes:

Multiculturalism suggests the need to recognize the variety of cultures within a society, each with their unique characteristics, as all of equal value. A criticism of this view is that it ignores differences in power among various ethnic groups which affect their lives in a society, manifested ultimately in racism (p. 454).

I should clarify here that Polaschek is critical of a *genre* of multiculturalism, one that is rooted in the Hegelian notion that identity is constructed through mutual respect and tolerance (Fraser, 2003: 23). Up until a few years ago, multiculturalism of this sort was the chief means through which struggles for recognition in Europe and North America were addressed (Phillips, 2007: 2-9).²⁷ This is reflected, for example, in Britain's Home Secretary Roy Jenkins' 1966 speech in which cultural integration (multiculturalism) is defined "not as a flattening process of assimilation but as equal opportunity, coupled with cultural diversity, in an atmosphere of mutual tolerance" (as cited in Phillips, 2007: 4). In any case, when rooted in such views of multiculturalism, transcultural nursing practices are problematic, Polaschek argues, because they do not recognize power inequalities between groups "manifested ultimately in racism." Recall, one of the tenets of cultural safety is to recognize institutionalized racism. To a certain extent, then, cultural safety is a practical example of what Fraser calls the status model of recognition because it seeks to redress "institutionalized relations of social subordination" and "institutionalized harm." However, given that cultural safety is premised upon bi-culturalism, which as

²⁷ According to Phillips (2007), this genre of multiculturalism is rapidly retreating (p. 8). In her book *Multiculturalism without Culture*, Phillips examines the circumstances around this phenomena and proposes an alternate version of multiculturalism, one that understands culture like gender and class—as "something that influences, shapes, and constrains behaviour, but does not determine it" (p. 10).

noted in Chapter 1, distinguishes between “original peoples” and “subsequent arrivals” (much like the distinction I make between Aboriginal and non-Aboriginal), and given that the status model of recognition maintains that “what requires recognition is not group-specific identity but rather the status of individual group members as full partners in social interaction” (p. 27), it is obvious, cultural safety and the status model of recognition are fundamentally distinct.

According to Annette Browne (2002) cultural safety is exportable to Canadian health care contexts involving Aboriginal patients. She argues, for example, “health care involving aboriginal peoples in Canada continues to unfold against a backdrop of colonial relations that shape access to health care, health care experiences, and health outcomes” (2005: 63). Here, Browne’s comments speak to cultural safety’s tenet “nurses are encouraged to acknowledge that colonization continues to inform Indigenous peoples situations.” Furthermore, Browne’s endeavour to show that health care providers’ attitudes and beliefs are influenced by their cultural mindsets (which I touched upon in section 3.4.1) is a reflection of cultural safety’s tenet “nurses are encouraged to recognize the negative stereotypes they may fasten to Indigenous peoples.” In her description of cultural safety, Polaschek (1998) elaborates on this point: “no health care interaction is ever simply objective. Rather the nurse always operates from her/his own cultural mindset which influences how she/he relates to those she/he care for” (Polaschek, 1998: 453).

That the tenets of cultural safety are exportable to Canadian health care contexts involving Aboriginal peoples is reasonable, given that both Indigenous peoples in New Zealand and Aboriginal peoples in Canada have endured colonization and continue to

live in colonial relations with the New Zealand state and the Canadian state respectively. Indeed, I am a proponent of cultural safety as a health care delivery model involving Indigenous and Aboriginal patients. However, I would like to point out, the primary aim of cultural safety is to foster *safer* biomedical environments by cultivating better patient-provider relationships. Such being the case, although cultural safety may be philosophically supportive of culture-based therapies—because one of its tenets is to nurture the wellbeing of Indigenous peoples and their identities—I believe that the task of bringing Indigenous or, in the Canadian context, Aboriginal healing traditions into urban medical facilities is beyond the scope of its primary aim. As a viable model for the task of bringing Aboriginal healing traditions into urban medical facilities, cultural safety comes close, but not close enough.

Chapter Four

Participants' Views: Aboriginal healing traditions can be integrated into urban medical facilities under specified conditions

In this chapter I turn to the views of the participants who helped to inform this study. The first half portrays the perspectives of those participants who feel that Aboriginal healing traditions can only be integrated into urban medical facilities if they do not impinge upon: 1) the will of physicians; 2) the patient's "normal" physiological status; and 3) the health and recovery of other patients. In the second half, I compare and contrast participants' views on the following topics: biomedical care; holistic health; Aboriginal healing traditions; sensory-friendly facilities and sensorial dimensions of health; and the credo equality of care. This is all to paint a clearer picture of the discourses influencing participants' views of integration, but also to show the diversity both across and within categories (e.g. "health administrator" or "practitioner of AHT").

4.1 The will of physicians must be considered and patients' physiological health must not be impaired

Louise, Karen, and Sally believe that it would be alright for Aboriginal healing traditions to be practiced within their facilities so long as they are practiced in designated enclosed spaces, such as multi-purpose rooms and Family & Visitor lounges. According to Louise, Aboriginal healing traditions would have to be practiced behind closed doors otherwise the physicians at her workplace would feel that their toes were being stepped on:

Louise: I think the barriers would be substantial in that physicians have a lot of power ...and I think they would feel very much that their toes are being stepped on.

Like Louise, Sally was aware of the fact that the use of Aboriginal healing traditions within her facility would not conspire if physicians did not have the upper hand. According to Sally, in the (unlikely) event that the facility where she works was able to accommodate a sweat lodge, physicians would have to be consulted and their expert knowledge taken into account:

Sally: My only concern with sweat lodges is, you know, the medical part of it: *it would definitely have to be ok-ed by the physician* because obviously when you're put in a sweat lodge or a sauna room your heart rate increases and, it depends on what the patient is in the hospital for, your core body temperature rises, that may be really contraindicated for that patient.

Karen, on the other hand, feels that Aboriginal healing traditions should be practiced in designated, enclosed areas because they might impinge upon the health and recovery of other patients. Below, Karen recalls an instance when the practice of smudging had been problematic:

Karen: I vaguely recall that they had a real problem with some of the smoke that came, because *it was not good for other patients who were having complications*.

Similarly, in the excerpt below, Sally notes that it would be more appropriate for drumming and singing to be practiced behind closed doors because the health of other patients would have to be considered:

Sally: If the patient could be moved out of the room, and they could go to one of our Family & Visitor lounges where they could close the door, maybe that would be more appropriate because *certainly there are other people in the hospital that are sick as well*.

Leonard and Susie, both Aboriginal health administrators, were the only participants to speak of scenarios in which Aboriginal healing traditions were not permitted indoors, but could be taken outside. In particular, Leonard spoke of a situation in which he and several practitioners of AHT were not permitted to drum inside a

particular hospital and, consequently, had to take their drums and songs outside. In a similar vein, Susie noted that Aboriginal healing traditions are not officially allowed to be practiced inside the facility where she works, which is why, for the most part, they are held outside on the facility's grounds.

Evidently, space, whether in or out of doors, is essential for the task at hand. And when space is not an option? Neither are Aboriginal healing traditions—at least this is the case at the facility where Crystal works where there is barely enough room for physicians to function let alone AHT practitioners:

Crystal: We don't have enough room as it is for all our doctors, and we do a lot of teaching—residents, medical residents, nurse practitioners, nurses—and *we don't have the physical space even for them never mind an Elder.*

Crystal feels sure that the facility where she works would neither be able to accommodate Aboriginal healing traditions indoors, due to lack of space, nor outdoors because the facility is situated in the city's impoverished downtown core. She feels that it would be inappropriate, for example, to ask patients to take their healing circles out onto the sidewalk: Not only would it block sidewalk traffic, it would violate the circles' terms of confidentiality.

Taking Aboriginal healing traditions outside poses another problem yet: inhospitable weather conditions. According to Smiling Stone, there is a need for more indoor facilities where Aboriginal healing traditions may be practiced because of the city's cool, wet weather.

Elena: Does it matter? The actual place that you're healing somebody in?

Smiling Stone: No it doesn't matter whether it's indoors or outdoors. There's a need for more indoor places because it rains so much out here.

4.2 Discourses at Work

Within section 4.1, Sally, Karen, Louise, and Crystal illustrate a way of thinking that supports and reproduces the biomedical paradigm: They commonly believe that Aboriginal healing traditions can be accommodated so long as they do not interfere with the delivery and receipt of biomedical care. This kind of accommodation, I argue, leaves neither users nor practitioners of AHT much choice in determining how, when, and where Aboriginal healing traditions may be used or practiced. That is left up to more powerful figures, such as physicians, executive directors, clinic managers, and regional health authorities. I believe Crystal's comment, *we don't have the physical space even for them never mind an Elder*, captures this power differential.

However, it should not be assumed that because Sally, Karen, Louise, and Crystal commonly put biomedicine before Aboriginal healing traditions they likewise share the same attitudes towards biomedical care. Sally, for example, feels that the medical facility where she works is pretty tolerant and accepting of people's beliefs and health practices because patients are allowed to use alternative therapies when physicians permit it. For certain, Sally is a supporter of biomedicine and hopes that people who use Aboriginal healing traditions do not solely rely upon them without taking biomedical advice into account. In contrast, Karen believes that biomedicine is very slow to alter its practices. For example, rather than being holistically oriented, biomedicine differentiates between acute and chronic care:

Karen: I think biomedicine is very slow to alter its practices ...you know we still have this model of acute care over chronic care, like we still separate things out as such.

Part of the problem, Karen argues, is that the health care system is designed so that health care providers do not have enough time to get to know their patients as whole people:

Karen: We don't take time with people and so we are attuned and conditioned to asking core questions like "What's the diagnosis? Ok it's not this, it's that" so we lose sight of the individual ...that's an artifact of our system: If we had time to understand a whole person and we actually engaged in personal conversation, and if our aim wasn't so driven to be diagnostic and treatment oriented ...I think some of these problems would fall away.

Louise, in contrast, describes biomedical care in rather holistic terms:

Louise: What we do here is—it's not fixing a wound—it's really developing a relationship with people because we work with people that have a lot of needs: They don't have adequate housing, they don't have adequate nutrition and they don't have adequate financial resources—they have quite complex health problems—so when somebody comes in with a scratch we don't approach it from, "Let's look at your scratch", we approach it from "How are things going? When was the last time you had something to eat? When was the last time you slept?"

Louise's comments about biomedical care are consistent with Julie's who recognizes that "health care isn't just whatever physical problem is wrong with you". She knows, for example, that there is a relationship between mental health and physical health, and vice versa, and that food, shelter, love, and a feeling of belonging are necessary to achieve optimum health. Comparable to Louise, Julie believes that the health care system strives to be holistic:

Elena: One of the beliefs commonly shared by Aboriginal peoples across the country and North America is the idea about holistic health or holism: Have you heard of that? The idea that health is not limited to individual physiology?

Julie: I think that would sort of be the goal that we were aspiring to—that we try to achieve—because health care just isn't whatever physical problem is wrong with you ...I know what the impact is of mental health on physical health and vice versa, so those two things are inter-related but I also know that you need sort of like basic needs to survive: love and belonging and shelter and food so all of those things are key and if you really want to heal someone or help them heal or achieve their optimum in life or whatever point they're at, you need to meet all of those needs and that's what we strive to do.

Crystal is also an advocate of holistic health. In fact, she is in support of Aboriginal approaches to health and medicine precisely because they are holistic:

Elena: Do you think that Aboriginal approaches to health and medicine would be beneficial to the general public?

Crystal: Yes, the more people that are aware of different aspects of holistic health—because that's what they've always talked about: the medicine wheel talks about holistic health—the more people that are aware of that and look for that the better. Ya, absolutely.

Elena: So because of the holistic aspect—if *people had medical treatment that was more holistic that would be good?*

Crystal: That would be good, that would be great, yes thank you for putting that into words.

In contrast to Louise and Julie's comments, Crystal's comments suggest that the health care system is in fact lacking in holism and/or that it could be more holistic than it is presently. Furthermore, if we consider Crystal's comments on the sensorial dimensions of Aboriginal healing traditions,²⁸ we see that medical facilities are not set up to accommodate Aboriginal healing traditions in their entirety—they are not set up to accommodate the very means through which Aboriginal healing traditions are realized:

Elena: Are there any sensory aspects to culturally competent health care?

Crystal: Absolutely, and that's part of the problem because *how do you put a sweat lodge in a facility like this or have sweetgrass burning, you know for fire safety and everything else, we're just not set up for that, but that's all part of their culture so how do you—we don't know how to fit that all in here—but definitely there's sight and sound and smell and everything else that goes with it which is hard to do in a Western based clinic.*

Thus, in spite of the fact that Louise, Julie, and Crystal commonly support holistic notions of health, the concept means something different to each of them. Notably, as

²⁸ I asked Crystal about the sensorial dimensions of culturally competent health care but her answer speaks to the sensorial dimension of Aboriginal healing traditions.

shown in Crystal's excerpt, problems arise when the concept is enacted by way of Aboriginal healing traditions.

Just as Sally, Karen, Louise, and Crystal have different attitudes towards biomedical care and holistic health, they have different attitudes towards Aboriginal healing traditions. For example, we already know that Crystal supports Aboriginal healing traditions because they are holistic and she is likewise a supporter of holistic health. Sally, in contrast, holds Aboriginal healing traditions with less esteem. As previously noted, Sally hopes that people do not solely rely upon Aboriginal healing traditions, in fact, she is under the impression that Aboriginal healing traditions are only beneficial to people who believe in or feel connected to them. Even then, she believes that Aboriginal healing traditions are only psychologically beneficial:

Sally: I think that things like touch therapy and music therapy are so beneficial, or can be so beneficial, and I'm sure with an Aboriginal person who has their health practices, or say they were to do some of them, I'm sure that would be psychologically—I don't know the actual, like if it actually *does* something—but psychologically it would do a world of good.

I think this excerpt is especially interesting because it reveals Sally's perception of Aboriginal healing traditions—something that is only psychologically beneficial—as well as her perception of psychological therapy—she is not sure whether psychological therapy (here, Aboriginal healing traditions) actually *does* anything. To be sure, Sally's logic is embedded in Cartesian dualism for it denies the relationship between psychological, physiological, emotional, and spiritual health and, simultaneously, implies that psychological health hasn't any “real” (physiological) consequences.

In a similar vein, Julie, Jay, and Ellen articulated the notion that Aboriginal healing traditions are only beneficial to people who believe in / are “open” to them.

According to Julie:

Julie: If you’re not open and you don’t one hundred percent believe what you are doing then the treatment’s not going to be effective because the person that you’re trying to serve won’t be able to receive anything from you knowing that you’ve got all those anxieties attached to it.

According to Jay:

Jay: I think if there’s a population that feels an affinity to / a belief in / an attraction to / an interest in Aboriginal medical practices or Aboriginal healing practices or philosophies I think absolutely—they would have a huge benefit. If somebody had an aversion to / a fear of—just because it’s unknown or foreign—it probably wouldn’t be ideal for them, you know, so I think it would depend on the population that you’re dealing with.

And, according to Ellen:

Ellen: I really do think you have to be open and willing to embrace the beliefs for them to be effective. I really believe that you’re not going to go anywhere with something unless you really believe it: You can block—psychically—you can block all sorts of things.

Elena: So for the general public ...that depends on whether or not people believe in it?”

Ellen: ...I really do think it’s important to have trust in the individual you’re with, and maybe you don’t believe *everything* they endorse but you have to connect to that individual.

Along the same lines, Karen is not inclined to use Aboriginal healing traditions herself because they do not “resonate” with her. Besides, she is apprehensive about appropriating someone else’s spiritual traditions.

Most likely, those participants who hold the view that the efficacy of Aboriginal healing traditions is influenced by the thoughts and feelings of the people who use them are referencing the placebo effect—“an inert substance or practice that has a general

effect”²⁹ (Csordas & Kleinman, 1996: 16). However, it is possible that they do not think Aboriginal healing traditions are “inert” as the definition implies, but simply patients’ thoughts and emotions *override* the potency of the traditions.

Whereas Sally, Julie, Jay, Ellen, and Karen’s comments speak to the efficacy of Aboriginal healing traditions—that is, their comments seem to suggest that the efficacy of Aboriginal healing traditions is influenced by the thoughts and feelings of its users—Louise’s comments speak to the efficacy of Aboriginal healing traditions in another way:

Louise: I was thinking more in terms, if an Elder wanted to come in and do something like a healing workshop or a healing time, like a healing morning, afternoon or hour, whatever, and wanted to do that in a group setting, in a room with closed doors, that we could probably do something like that, it would be kind of interesting. *I’d probably have to get some approval, but I think if there was some health benefit to it, that um, I think that it would be interesting to try it.*

In other words, if Louise can show that Aboriginal healing traditions are efficacious in some way, it is likely they will be “approved” (by the health authority). In retrospect, I should have asked Louise whom she would consult on the matter: Would an Elder’s perspective on the efficacy of Aboriginal healing traditions be sufficient or would she have to draw upon evidence-based research? Certainly, this issue of efficacy is pertinent to my research question and I address it further Chapter 5.

I would also like to point out that Louise’s attitude towards Aboriginal healing traditions parallels her attitude towards sensory-friendly facilities. For example, in spite of the fact that Louise believes the idea of sensory-friendly facilities is “neat” and “fascinating to think about” she believes the concept would be problematic from an inspections point of view. Comparably, Sally believes that the concept of sensory-

²⁹ In Csordas and Kleinman’s (1996) article on “the therapeutic process” it is noted that non-medical healing is conventionally thought to be based on pure imagination or superstition and to be efficacious only as a placebo” (p.5).

friendly facilities is “good” if there is a demand for them. She does not, however, believe that conventional medical facilities, such as walk-in clinics, could be persuaded to accommodate multi-sensorial healing traditions. Julie’s attitude towards sensory-friendly facilities follows a similar trajectory, but is comparatively more skeptical. Although Julie believes that the concept of cultural competence should tolerate multi-sensorial cross-cultural healing traditions (e.g. saging), she is skeptical whether sensory-friendly facilities are in fact possible:

Julie: Depending on how many cultures you’re bringing in—is there anything that is going to clash when you bring those two groups together? ...If you want to take it down to where you can touch it and feel it, then you’re going to have to think about who you are going to be able to bring in because you won’t be able to bring in everybody, you just wouldn’t, no you wouldn’t be able to bring them all in and you would have to have the backing in order to do it.

Karen was the only participant to note that medical facilities already comprise an abundance of sensorial dimensions: sterilization as odor; humming computers and light fixtures as sound; and visually, everything comes in “white, white, white”. Admittedly, this is a good point and I wish I had thought of it myself: Medical facilities are indeed multi-sensorial—they exhibit and accommodate visual, auditory, olfactory, and tactile dimensions of biomedicine and/or biomedical health care. However, I would not go so far as to say that they are *sensory-friendly* facilities because, for example, they do not accommodate smudging and/or smoke—the product of burning tobacco, sage, sweetgrass, and cedar—a key component of Aboriginal healing traditions.³⁰ Julie and Sally’s comments speak to this conundrum:

Julie: Well there’s a smoke free policy at [our health authority] which is a key component of their practices so that would probably get lost, you know, I can see

³⁰ Recall, in Chapter 1, I state that sensory-friendly facilities are capable of managing auditory, olfactory, and visual byproducts of multi-sensorial *cross-cultural* approaches to health and medicine.

that that would probably be one of the first things that would get lost in bureaucracy trying to get that approved.

Sally: We have a No-Smoking by-law in [this city] in general and in Canada I think ...so that may be the only thing that I can see being an issue.

Here, I would like to point out that Sally and Julie talk about smudging in terms of its physical / sensorial dimensions (smoke) and not its *spiritual* ones. They point out that smoking is prohibited and because Aboriginal healing traditions involve smoke, Aboriginal healing traditions are destined for bureaucratic troubles.

One wonders if smudging would be as problematic in medical contexts if it were more readily perceived in spiritual or religious terms—as a practical means through which spirituality or religion is tended. This is an important point, I think, because it goes to show that the way in which Aboriginal healing traditions are recognized—as either “medicine” or “religion”—has political implications. In her book *Multiculturalism without Culture*, Anne Phillips (2007) posits a discussion on cultural defense.³¹ Here she argues, “religion is widely recognized as a basis for legal exemption. Extending the same status to culture is said to veer too far in the direction of different laws for different communities” (p. 80). In other words, Phillips is saying that religion, more so than culture, is readily accepted as a means to explain people’s actions in court. In other words, the concept of religion has more sway than the concept of culture in its capacity to influence legal processes. I think her argument has important implications for the use of Aboriginal healing traditions in the context of urban medical facilities: If Aboriginal healing

³¹ Cultural defense refers to the act of employing culture to explain people’s actions in courts of law.

traditions are recognized as “religion”, as opposed to “culture” (e.g. as a means to celebrate Aboriginal culture), they might be more readily accepted.³²

Admittedly, in the context of this thesis, I talk about Aboriginal healing traditions in sensorial terms more so than spiritual terms. This is a reflection of my once limited understanding of Aboriginal healing traditions: At the onset of my research, I thought that traditions such as smudging and drumming were intended to engage one’s sensorial faculties—an assumption I made after reading certain literary works in the anthropology of the senses (e.g., Laderman & Roseman, 1995; Desjarlais, 1992). As such, I cast Aboriginal healing traditions in sensorial terms as opposed to spiritual terms. For example, I would explain to participants that Aboriginal healing traditions, such as smudging and drumming, were *sensorial* dimensions of care. Half way through my research, I came to realize that this was not the case. When I asked Smiling Stone about the sensory aspects of smudging—if it was meant to engage one’s sense of smell—he said this:

Smiling Stone: The Old Ones used to say that when we smudge ourselves we’re removing our human scent because our human scent to spirits is kind of repulsive ...and the spirits are able to work closer with [us] that’s why we always smudge somebody before a healing process. Plus it puts them mentally in a sacred state.

In effect, the point of smudging, according to Smiling Stone, is to facilitate one’s connection to spirit—to one’s guardian spirits (by way of smelling less humanly and/or repulsively), as well as to one’s own spirit (by creating a sacred state of mind). This latter

³² Sally, one of the non-Aboriginal health administrators who helped to inform this study, told me during an interview that she believes Aboriginal healing traditions are a means for Aboriginal people to celebrate their culture. I think this goes to show that Aboriginal spirituality (religion) is seriously lacking in recognition in Canadian society and within health care institutions—indeed, Sally is a representative of both milieus. Not surprisingly, the health care institution where Sally works has but chaplain services.

point—that smudging induces a sacred state of mind—arises because smoke is a purifier; it has the capacity to remove “negativity”. According to Smiling Stone:

Smiling Stone: That’s the purification: the smudging, using the sage, the different things that we put into the smudge pot, and what that does is it removes the negativity ...you look at it historically, when the plague was going around, they had a fire going around the Pope 24/7 because they knew then that smoke is a great purifier: Disease doesn’t like smoke.

Ellen’s comments on the value of smudging are compatible with Smiling Stone’s. According to Ellen, smudging opens the mind to “seeing” and effectively facilitates one’s connection to spirit:

Elena: Burning sage is not to smell it necessarily, I don’t think.

Ellen: No.

Elena: But to try to talk with the spirits?

Ellen: To connect: It’s to open the mind to seeing.³³

The same can be said about drumming: It is not meant to engage one’s sense of hearing but to stimulate an open mind:

Elena: And what is the point of drumming?

Ellen: Ya, well I think it’s a sonorous rhythm. Music plays a huge role in stimulating an open mind, leading you in a direction, and music is spiritual ...when you think about a new level of openness—your mind moving up into a new way of seeing—you can talk about that as a high vibrational level. Have you read much about vibrational medicine?

When I asked Smiling Stone about the value of drumming, this is what he said:

Smiling Stone: If a person is drumming on a hand drum, the hand drum represents your own personal heart. We call it a heartbeat. In the ceremonies we bring in the heartbeats right, so if you have a hand drum and you’re feeling bad right, and you’re playing that drum, what it does is it’s just magnifying what you have inside your heart outside.

³³ For further discussion on synaesthesia—the crossing of sensorial faculties—please see Howes (2004).

Interestingly, Ellen and Smiling Stone's comments about drumming challenge the notion that the efficacy of Aboriginal healing traditions depends upon the thoughts and feelings of its users. Here, in contrast, drumming is depicted as something that has the capacity to manipulate the mind (to open it through vibrational resonance) as well as the body (to magnify and/or expel bad feelings from the heart). In other words, people's thoughts do not override the potency of the traditions, but rather the potency of the traditions overrides and manipulates people's thoughts and physiological statuses.

To substantiate this claim, I offer an excerpt from my fieldnotes in which I recount Smiling Stone's experience drumming for an Aboriginal man at an intensive care unit:

At first the staff was uneasy about the whole thing. They said it would be too noisy. Sure enough, they beat on the drums very powerfully and sang loudly. The man's whole family was there too. In the end, he lasted for a while longer. Smiling Stone told him that if he were to return to his family, he would not be the same as he had been—he would not be able to provide for them as he had done before. The other option would be to go home³⁴. He decided to go home. Smiling Stone said that the nurses who were standing outside of the room said it was one of the most beautiful things they had ever heard and that *all of the other ICU patients who were there at the time recovered very well* (May 30, 2007).

Although Smiling Stone did not say to me explicitly “drumming affects people in spite of what they think or how they feel about it”, this is implicated in the last sentence of this excerpt. Given that most if not all ICU patients are either unconscious or drifting in and out of consciousness,³⁵ it is probable that the patients who were present at the time of Smiling Stone's drumming were not influenced by their thoughts and feelings about drumming. In this way, then, it can be said that drumming has the potential to affect

³⁴ “Home” is where one goes when his or her physical body dies.

³⁵ I make this claim based on personal experience visiting family members who, unfortunately, have had to spend time in ICU units.

people's health in spite of their thoughts and feelings—at least this is what Smiling Stone's interpretation of the ICU event seems to suggest.

Like Ellen and Smiling Stone, Blackbird described Aboriginal healing traditions in spiritual terms but he took me by surprise when he told me that he uses his *own* senses to better understand the spirits with which he seeks to communicate:

I asked [Blackbird] if he thought that sensorial engagement was a part of the healing process (like sight, sound, smell touch, etc.). I said, "you know like the drum beating or you chanting?" He smiled and paused. He said that when he goes into people's houses to cleanse the spirits—to tell the spirits that it's "ok" for them to leave—he can smell the acts of life that had something to do with the spirit's embodied life before it died (June 08, 2007).

That Aboriginal healing traditions are spirit-centered (they are powered by and/or tended to via one's connection to spirit)³⁶ as Smiling Stone, Ellen, and Blackbird's comments have shown, it is clear that the use of Aboriginal healing traditions within urban medical facilities is more than an issue of integrative medicine or cross-cultural healing practices: It is an issue of equitable access to spirituality or religion.

Insofar as Aboriginal healing traditions are spiritual and/or religious, I believe that the challenges pertaining to the use of Aboriginal healing traditions within Canadian health care institutions mirror the problem of Aboriginal spirituality in Canadian corrections institutions in the early 1980's. In his book on the Aboriginal spirituality in Canadian prisons, Waldram (1997) recounts the story of two Aboriginal cousins, Dino and Garry Butler, who were instrumental in bringing Aboriginal spirituality into Canadian prisons. Before then, "Aboriginal inmates were not afforded the same rights as non-Aboriginal inmates to celebrate their faith" (p. 9). Before the Butlers succeeded in obtaining permission to perform rites using an eagle feather and a pipe, the Native

³⁶ The word "spirit", as in "spirit-centered" refers to both one's own spirit as well as other spiritual beings including the Creator.

Brotherhood at Kent institution had asked for access to these on their behalf. The eagle feather and pipe were tolerated under highly restricted conditions: They would need a permit to carry an eagle feather and would have to inform administration as to where, when, and how the pipe would be used. In response to these conditions, the Brotherhood responded: "We ask you: Can a Catholic priest perform a ritual mass without an altar stone? Must a Christian fundamentalist notify the administration when he wants to carry his Bible to the prison yard or prison chapel? We think not" (p. 11). Waldram speaks to the essence of the dilemma in the passage below:

Conceptually, equating Aboriginal Spirituality with Christian faiths is Eurocentric. It implies that these faiths are the standard to which Aboriginal spirituality, a presumably any other non-Christian religion, is to be compared. Such an approach, in addition to being culturally and morally repugnant, necessarily limits the availability of Aboriginal services to those that have Christian parallels. Hence, "equality" is, in effect, inequality (p. 17).

I think Waldram raises a good point when he writes, "equating Aboriginal Spirituality with Christian faiths...necessarily limits the availability of Aboriginal services to those that have Christian parallels". I think a similar case can be made for Aboriginal spirituality in Canadian health care institutions: If a Christian is allowed to hang a cross over his or her hospital bed (which is allowed), should not a person who practices Aboriginal healing traditions be allowed to hang a cedar bough (which is not allowed)? If a Christian is allowed to bring a bible into the hospital (which is allowed), should not a person who practices Aboriginal healing traditions be allowed to bring in, and to use if he or she is able, a sacred pipe (which is not allowed)? Such questions, I argue, should not be interpreted as questions of "equality" but as questions of "equity". I will elaborate. A health care system that provides cookie-cutter parameters for religious practices to which

all patients have “equal” access, is different from one that seeks to create a space (ideological and physical) in which religious practices of all kinds may be enacted. The former seeks to provide equal access to *perceptibly* normal and/or dominant religious practices (e.g. reading religious scriptures) and the latter seeks to create a situation in which even *abnormal* religious practices (Cedar boughs to deter mischievous spirits) may be enacted.

Just as there is a tendency to impose a Christian framework for tending to unconventional modes of spirituality and/or religions, I think there might also be a tendency to impose mainstream notions of holistic health onto unconventional ones. As I have tried to show, participants conceptualize holistic health in various ways—and whereas some participants feel that health care *is* holistic (namely Julie and Louise) others feel that it could be a lot more so (namely Crystal and Karen). Significantly, however, when holistic health is conceptualized and enacted by way of Aboriginal healing traditions it is viewed as a problem. Recall, Crystal believes that Aboriginal healing traditions are holistic but that sweat lodges and other means by which Aboriginal healing traditions are enacted are problematic in Western medical clinics. Indeed, holistic health via Aboriginal healing traditions looks, feels, sounds, and smells different than its conventional counterparts. As such, the crux of this issue is not whether conventional health care is holistic, but rather *to what extent and in what way* is conventional health care holistic? Better yet, *whose notion(s) of holistic health does conventional health care uphold?* Unless this bias is recognized in health care contexts, I argue, only the most mainstream and/or normal notions of holistic health will be readily tolerated. The rest

will be seen as “special” requests, which will have the effect of steering health care providers away from the credo “equality of care”.

As discussed in Chapter 1 of this thesis “equality of care” is one of health care culture’s underlying credos. For example, Browne (2005) notes in her study on the discourses influencing nurses’ perceptions of Aboriginal patients: “as the nurses discussed the diverse patients they encountered, they reiterated that they were committed to treating all patients equally” (p. 76). “Equality of care” was indeed a vibrant conversation piece in this thesis insofar as it was interpreted in multiple and disparate ways, including: 1) “don’t give patients preferential treatment”; 2) “treat everyone the same”; 3) “deliver excellent care to each patient”; and 4) “honor the individual”. It was not uncommon for participants to adopt one or more of these interpretations over the course of their interview. As it turns out, the concept “equality of care”—when interpreted as “treat everyone the same” and “don’t give patients preferential treatment”—significantly influenced health administrators’ views on what constituted reasonable or appropriate care and, in some cases, directly impacted their views on the use of Aboriginal healing traditions within urban medical facilities.

The concept “equality of care” held two meanings for Sally who understood the concept as “no preferential treatment” as well as “treat everyone the same”. In the passage below not only does Sally reveal her belief that health care providers are supposed to treat everybody the same, she goes so far as to reject circumstantial information related to a given patient’s injuries for fear that it might cause her to treat that patient “differently”—although here, I would argue the word “differently” is tantamount to “more compassion”:

Sally: Like in health care *we're supposed to treat everybody the same*, so the more you know about some of [your patients' past experiences] automatically makes you treat them differently: If I know that I'm taking care of a patient who was assaulted after she was raped versus a patient who came in after she was hit by a car, [because she was] crossing the street, even if they had the exact same injuries, which would be unlikely, but even if they had the exact same injuries, knowing that background information is going to make me treat them differently, I would treat them differently.

In other words, knowing that patient "A" attained her hip injury as a result of rape might propel her to treat that patient with more compassion than patient "B" who attained her hip injury as a result of being hit by a car. Further, she might be inclined to think that patient "A" has "the right" to feel badly about her hip injury and that patient "B" does not. In effect, Sally opts to know less information about her patients in an attempt to uphold the credo "equality of care" as she understands it. Consider also the following:

Sally: We are supposed to treat all patients the same whether—

Elena: Who taught you that?

Sally: The school—

Elena: School?

Sally: Ya, it's just kind of the hospital policy—

Elena: At [this hospital]?

Sally: Mhmm [yes]

Elena: Who taught you that at [this hospital]?

Sally: I don't know, *that's medical standard—you're supposed to treat everybody the same*.

Furthermore, Julie, who had claimed to be partial to the notion "equality of care" as "deliver excellent care to all patients", in fact demonstrated her partiality to the notion "equality of care" as "treat everyone the same". In the excerpt below, Julie is responding

to my question as to whether or not she feels multi-sensorial dimensions should be a component of culturally competent health care. Although it may not be explicit, I believe Julie's response adheres to equality as "treat everyone the same":

Julie: Umm...well absolutely, but it would depend on what the investment was that you had from [the Health Authority]; I mean you could go, you could do that as deeply as you are able to but you would have to have the support of wherever you were working, you know, because it would look different and because *you would have to be culturally sensitive to remember that for everyone*, right, so how many cultures?

On another occasion, Julie's adherence to "equality of care" as "don't give patients preferential treatment" directly impacted her views on the use of Aboriginal healing traditions within urban medical facilities:

Julie: Well there's a smoke free policy at [our health authority] which is a key component to their practices, so that would probably get lost, you know, I can see that that would probably be one of the first things that would get lost in bureaucracy trying to get that approved and, you know, *"well it's ok for them, maybe it should be ok for someone else"*, and then maybe what if somebody wants to come in and smoke marijuana for healing purposes, you know, I can see that it would open up a lot of other doors *just because one group's doing it maybe another group should be able to do it too*.

It is interesting to note that Julie is a supporter of patient-centered care, which, as discussed in section 3.4.2, entails putting patients' preferences first. However, as shown in the excerpt above, Julie's commitment to not give patients preferential treatment outweighs her commitment to patient-centered care. Louise, also a supporter of patient-centered care, makes a similar move. In the excerpt below Louise is responding to my question about the meaning of the credo "equality of care":

Louise: I wouldn't say "equally" is the right word

Elena: This is what I've heard from some nurses

Louise: That would be hard to do: Not everybody needs the same care ...I think a better way of expressing the concept [equality of care] is that we treat people as

people first so it isn't about "you're a street sex-trade worker", you know, "you're an IV drug user or in a methadone maintenance program", or "you're homeless or mentally ill" or "you're Aboriginal", you know, these are people first so I think that is the underlying philosophy here and I think *care is provided around what the patient's needs are*.

However, in this next excerpt, it appears that Louise is committed to the credo "equality of care" as "don't give patients preferential treatment":

Louise: And then there's that whole question of *what about all the other cultures that we serve?*

Elena: Absolutely.

Louise: Because we serve other cultures as well as Aboriginal folks so maybe the other cultures wouldn't like that here.

4.3 Discussion

Embedded in the patterns of thought upheld by participants in the first half of this chapter is that Aboriginal healing traditions can be integrated into urban medical facilities *provided* they adhere to biomedical paradigmatic constraints. Such a situation, I have argued, does not give the users and practitioners of AHT much choice insofar as what, when, where, and how Aboriginal healing traditions are employed. I think it is interesting to note that the participants who articulated this pattern of thought (Louise, Sally, Karen, and Crystal) are all non-Aboriginal health administrators who (except for Crystal) also believe that Aboriginal healing traditions are only beneficial to people who believe in them; that is to say, they commonly discount spiritual power as having an effect above and beyond mind power.

Interestingly, participants' views pertaining to sensorial dimensions of healing and sensory-friendly facilities do not seem to influence their views pertaining to the use of Aboriginal healing traditions within urban medical facilities. Rather, it appears

participants' willingness to reproduce the biomedical paradigm affects their views pertaining to sensorial dimensions of healing and sensory friendly facilities: Because participants do not think sensorial dimension of healing would be supported by the health authority, they are doubtful that they will materialize within urban medical facilities. And because some of them believe that it is impossible to accommodate each and every cross-cultural healing tradition within the same structure (because they might "clash"), they believe that sensorial dimensions of healing and sensory-friendly facilities would be unfair to those individuals whose culture-based sensorial healing traditions get left out. In other words, just as participants' views pertaining to the use of Aboriginal healing traditions within urban medical facilities are affected by their willingness to reproduce the attitudes and relations of power that the biomedical paradigm upholds, their views pertaining to sensorial dimensions of healing and sensory friendly facilities are likewise affected—that is, they are doubtful sensorial dimensions of healing will materialize in Western medical facilities.

Also noteworthy is that Sally was the only participant to explicitly conceptualize the credo "equality of care" as "treat everyone the same". This is fascinating and perhaps it has to do with Sally's age; she is approximately twenty years younger than the others. Had I not known that Crystal and Sally have been working in health care for the same amount of time (six years), I might also have drawn the conclusion that Sally's interpretation of "equality of care" as "treat everyone the same" is a reflection of her relative inexperience working in health care. It is also interesting to note that Sally said she learned to treat all patients "the same" in nursing school, but that that was also the "medical standard" at the hospital where she works. This, in effect, eliminates Sally's

nursing school, a Canadian university that she attended between 1999 and 2002, as the sole progenitor of the credo “equality of care” as “treat everyone the same”. In other words, the medical institution where she works is likewise responsible.

Also significant is the way in which Julie and Louise *conceptualize* the credo “equality of care” as “deliver excellent care to each patient” and “honor the individual” respectively, yet they *enact* the concept as “treat everyone the same”. This particular phenomenon, I have argued, has significant implications with respect to the use of Aboriginal healing traditions within urban medical facilities. Indeed, when these two non-Aboriginal health administrators enact the credo “equality of care” as “treat everyone the same”, the kind of “equality” that is mobilized as a result is homogenizing; it does not recognize that some Aboriginal patients might require “special” care, “extra” compassion, or access to Aboriginal healing traditions to compensate for emotional, spiritual, physical, and economic deficiencies instigated by and/or related to colonial oppression (e.g. residential schooling). In other words, when health care providers enact the credo “equality of care” as “treat everyone the same” they effectively rationalize that all people possess the same mental, emotional, spiritual, physical, and economic capacities—thus denying historical and current power dynamics.

Indeed, with such an understanding of equality embedded in health care culture, I question how both cultural competence and patient-centered care fit into the picture. If health care providers are committed to treating all patients the same—to put no one’s needs above anyone else’s; to treat one patient with not more or less but the same amount of compassion as all of the others—how can they be culturally sensitive? How can they be patient-centered? This in turn raises the question: *How much and what kind of care*

and/or compassion are health care providers delivering in equal amounts? To reiterate Polaschek's (1998) observation—"the nurse always operates from her/his own cultural mindset which influences how she/he relates to those she/he care for"—it can be said that what constitutes excellent care from one nurse's point of view is not necessarily going to constitute excellent care from another's. Moreover what constitutes a "normal" request from a patient may be interpreted differently by different nurses. For example, the practice of bringing flowers to bed-ridden patients is a common occurrence across North America; it is, by and large, "normal". Less "normal" is the practice of bringing cedar boughs to bed-ridden patients and because of this—because it is *abnormal*—it is more of a "special" request and therefore far more likely to be turned down in the name of "equality". Indeed, for Susie, the concept "equality of care" is one of the most frustrating aspects of health care culture—a barrier that Aboriginal people have to fight with everyday:

Susie: When we talk about "options" and "being equal" then we should have equal opportunity. If someone is going to be able to place a cross over their bed, then we should be able to place a cedar bough. That's what I see as equality: We treat people *differently*.

At this point, I would like to return to Fraser's (2003) status model of recognition. Recall in the introduction of this thesis, I note that the status model of recognition aims to replace "institutionalized value patterns that impede parity of participation with patterns that enable or foster it"(p. 28). In the context of the discussion above, I think this mandate has pertinence. Let us assume that the credo "equality of care" is this institutionalized value. This value, when conceptualized (in Sally's case) or enacted (in Julie and Louise's case) as "treat everyone the same", effectively impedes patients from hanging cedar boughs over their hospital beds. To redress this impediment, then, the status model of

recognition would replace the value pattern “treat everyone the same” with the value pattern “honor patients’ individual needs”, a value pattern that would, in effect, enable and/or foster the practice of hanging cedar boughs over hospital beds. Indeed, if health care culture adopts the value pattern “honor patients’ individual needs”, the use of Aboriginal healing traditions within urban medical facilities *might* be readily accepted.

In this chapter, I illustrated the views of those participants who feel that Aboriginal healing traditions can be integrated into urban medical facilities under specified conditions. I then discussed participants’ views on a variety of topics, such as holism and “equality of care”, which produced a diverse collection of perspectives that permeated categorical boundaries. Recall, for example, health administrators Julie, Karen, and Crystal conceptualize holism in various ways. This range of transecting perspectives made it difficult for me to make claims such as, “health administrators believe X” or “Aboriginal people believe Y”. However, I would like to highlight one definite trend: the practitioners of AHT are the only participants in this study who do not suggest that the efficacy of Aboriginal healing traditions is dependent upon the thoughts and feelings of its users.

Chapter Five

Participants Views: A number of conditions have to be met before Aboriginal healing traditions should be integrated into urban medical facilities

This chapter presents the views of those participants who believe that all parties will not be satisfied with the project of integrating Aboriginal healing traditions into urban medical facilities until a number of internal and external conditions are met. To be clear, “internal conditions” refers to those affairs for which the biomedical community is responsible, and “external conditions” refers to those affairs for which the larger society is responsible.³⁷ These conditions were depicted by participants in the following ways: 1) members of the dominant society have to accept Aboriginal healing traditions; 2) members of the dominant society have to recognize Aboriginal healing traditions as efficacious; 3) health care providers have to be open to alternative views; 4) Aboriginal people have to trust members of the dominant society; and 5) there has to be an increase in Aboriginal health care providers.

5.1 Members of the dominant society have to accept Aboriginal healing traditions

According to Julie, Aboriginal healing traditions are not presently recognized by the dominant society and that will have to happen before users and practitioners of AHT find a place for themselves within urban medical facilities. According to Julie, “another generation” will have to pass before non-Aboriginal people come to accept the presence of Aboriginal healing traditions in their medical centers:

³⁷ In reality, of course, there is overlap: Physicians are members of both the biomedical establishment as well as society at large, making it difficult to determine where the onus actually lies. Whether or not a physician chooses to be open to alternative medical views is as likely to be influenced by his or her own personality as well as the attitudes and beliefs upheld by the social milieu in which he or she moves in everyday life as it is to be influenced by the attitudes and beliefs upheld by the biomedical establishment.

Elena: When you say “next generation”, do you mean the next generation of Aboriginal people or of the health care establishment?

Julie: Both. I mean both. You’d have to go through, you know, forty years is a generation, you’d have to go through that group of people to raise their level of accepting new practicing into their medical care.

Blackbird also noted that Aboriginal healing traditions are not, at present, prepared to integrate because Aboriginal peoples do not trust the dominant society (which I address in section 5.4) and because Aboriginal healing traditions are not presently accepted by the dominant society. I offer an excerpt from my fieldnotes:

He said that we are not quite ready for an integrative medical setting that would involve Aboriginal doctoring. We’ve got to wait another generation. “A generation of who: Aboriginal peoples or health care providers?” He said both: Aboriginals don’t trust whites, and whites don’t accept our ways (July 05, 2007).

Susie was the only participant to note that the use of Aboriginal healing traditions within urban medical facilities will not become accepted until the dominant society comes to understand what happened to Aboriginal peoples historically. According to Susie, the Canadian government has to take full responsibility for the wrongdoings inflicted upon Aboriginal peoples, such as residential schools, by educating all members of society—not just health care providers:

Susie: There are certain things that we have to do to improve education about cultural issues and getting it out there, and until the government actually takes that full responsibility you won’t see it across Canada, you won’t see it nationally, you’ll just see individual groups fighting for that. ...It should be in all education at all levels, not just health care providers. We’re talking at every level. People need the base lines. If you think about, you know, social work and teachers that work within the hospital, they need the base lines as well right, even though they’re not actually doing hands on care with that individual, they’re caring for that individual in another way, so they need to have that understanding.

What is interesting about Susie’s comment is that she makes a direct correlation between understanding and accepting: If non-Aboriginal people understand what happened to

Aboriginal peoples historically, they will be in a position to accept Aboriginal healing traditions.

5.2 Members of the dominant society have to recognize Aboriginal healing traditions as efficacious

Similar to the idea that members of the dominant society have to accept Aboriginal healing traditions is the idea that they have to recognize them as efficacious.³⁸ Ellen was the only participant to express the belief that the use of Aboriginal healing traditions within urban biomedical facilities would have to be executed in accordance to the needs and desires of its users and practitioners—a condition, I argue, that would have to be predicated upon either the acceptance of Aboriginal healing traditions, or alternately, the recognition of them as efficacious. As a user of Aboriginal healing traditions, Ellen noted that she would not feel comfortable being treated by her Elder unless he had access to all of his tools and she could be treated in an environment that was “aboriginally oriented”:

Ellen: I think if my elder was sitting in there [a doctor’s office], with all of his tools around him and the setting was aboriginally oriented, then I would probably feel quite comfortable there. I don’t think I would feel comfortable in a green walled medical room in a hospital talking to him, no. I think that would take away [from it] and I would want him to take me out of there.

From Isabelle’s perspective, Aboriginal medicinal knowledge is not recognized as being “good”, as noted in the excerpt below:

Isabelle: We’ve got various ethnic medical practices throughout the country and they are all recognized and appreciated and acknowledged that this is good. Why has there not been that acknowledgement, recognition of what we have as far as information goes, as far as practice goes, as far as using it, you know, the

³⁸ To be clear, “accepting” Aboriginal medicine and “recognizing” Aboriginal medicine as efficacious are mutually exclusive. Although I am aware that acceptance is often predicated by efficacy, I believe that it is possible to accept something without necessarily recognizing it as efficacious.

practical end of it, and to give recognition, acknowledgement? Finally, we're getting recognition for the traditional environmental knowledge and how we kept a balance and how we still practice that traditional environmental knowledge. That's being recognized today by people at you know—

Elena: David Suzuki?³⁹

Isabelle: Yes

Elena: I heard a wonderful speech by him

Isabelle Ya? So there's the recognition that we have that knowledge: *Why isn't there recognition that we also have medicinal knowledge?*

Isabelle's comments highlight the integral connection between recognition and efficacy. Aboriginal medicinal knowledge is not simply unacknowledged as a viable medical system; it is unacknowledged as an *efficacious* one. In the excerpt below, Leonard does not make particular reference to society's lack of acceptance or recognition for Aboriginal medicinal knowledge however his comments do speak to the quandary of efficacy:

Leonard: As far as liability goes, just say it's an Elder—now you don't want some Elder coming in and, he'll explain what he's going to do, if it's traditional or just something—he's not going to come in and shoot a guy up with 50 cc's of spruce sap. Ya there's got to be (pause) *the only thing that the medical people have to understand is that it's done in a good way, and they won't go against it.*

In light of Isabelle and Leonard's comments, I would like to posit a short discussion on the issue of efficacy. If we accept that biomedically informed methodologies (e.g. evidence-based research) are inept at demonstrating the efficacy of Aboriginal healing traditions—as discussed in Chapter 3—we must also acknowledge the arduous task of getting people to accept Aboriginal healing traditions as efficacious in the absence of conventional proof. Not only does this present a challenge for those members

³⁹ In May 2007, I helped to organize a conference for the Association of Complementary and Integrative Physicians of British Columbia. Geneticist and environmental activist David Suzuki, one of the guest speakers, spoke about the value of traditional Aboriginal knowledge pertaining to ecosystems.

of society who sanction biomedical practices and philosophies, it presents a challenge for those members of society who are judicious of them also. Take Denver, for instance. As the CEO of an integrative medical facility, Denver feels that our current health care model should be more holistic. In spite of this conviction, Denver is not exempt from drawing conclusions about alternative therapies based on clinically proven, evidence-based research. Although this was not communicated to me in so many words, I am aware that it is the mandate of the facility where Denver works to advance evidence-based alternative therapies. To further illustrate this point consider, for example, Denver's perception of saging. According to Denver, saging is useful because it brings attention to the energy within a room. From a traditional Aboriginal perspective however the health benefits associated with saging are manifested in its ability to connect people with spirit; it is a means through which people's prayers are transported to the spirit world and a means by which one neutralizes his or her humanly scent so as not to offend the spirits with which he or she wishes to connect. To be sure, energy and spirit are not one and the same, at least not according to Blackbird, who told me frankly: "Energy doesn't speak to you in your dreams". Put simply, Denver does not determine that saging is efficacious based on principles born from traditional Aboriginal knowledge (e.g. smoke is a vehicle for communicating with spirits) but from a principle born from science (e.g. smoke manipulates the energy in a room). Conscious of it or not, Denver is judging Aboriginal healing traditions by biomedical standards.

When I asked Blackbird what he thought about the idea of subjecting Aboriginal healing traditions to evidence-based research he scoffed with disbelief. The biomedical community, he said, would both ridicule his perception of illness and be disturbed to

know that his view of a “successful treatment” does not always amount to healing or curing his patients’ sickness’ in the conventional sense.

5.3 Health care providers have to be open to alternative views

Different from the belief that Aboriginal healing traditions have to be recognized as efficacious prior to integration is the view that health care providers have to be open minded and accepting of alternative views. Ellen was the only participant to note that Aboriginal healing traditions cannot be integrated into urban biomedical facilities *unless* health care providers are open to alternative views:

Elena: Your experience with Smiling Stone, like the different treatments that you had: Could any of them have taken place in a medical facility?

Ellen: No

Elena: None of them?

Ellen: No (pause) I suppose I could have had a chat with a well-informed, open-minded health care provisioner who might have been able to sympathize with my perspective but I certainly never felt that I could safely talk to anybody [at a particular medical facility]—and it wasn’t that I was afraid it was just simply that it wasn’t relative to their way of thinking.

I would like to stress here that Ellen is not saying that health care providers have to recognize the efficacy of Aboriginal healing traditions in particular, but rather *health care providers have to be open to views about health and medicine in addition to the ones biomedicine upholds*. Jay and Denver are the only other participants who expressed partiality to this view. According to Jay, there is no reason why Aboriginal healing traditions cannot be integrated into the center where he works because it is an “open environment”:

Elena: Are there any specific approaches that couldn’t be incorporated into the clinic?

Jay: Um (long pause) I'm trying to think about this so I answer it mindfully (pause) I can't think of anything that wouldn't. I mean, again, this is a very open environment; if it's what people want, we're pretty much open to putting it in place and I don't think we have the restrictions against that.

Denver too is open to alternative medical views and supports a model of health care that is much broader than the one currently in place:

Denver: I think we can learn from all of those traditions while at the same time recognizing the value that conventional medicine has—so not necessarily throwing the baby out with the bath water but creating an integrative system that is much broader than our current illness model.

In fact, the center where he works espouses the philosophical tenet to support patients' thoughts, beliefs, views and values around their illness:

Denver: Yes, I think we have as a basic tenet of our philosophy that we support people in their thoughts and beliefs around their illness and individualize their experience according to their own views and values, whether it's cultural views or their own individual views.

5.4 Aboriginal people have to trust the dominant society

Four participants in this study expressed the view that the integration of Aboriginal healing traditions into urban medical facilities hinges upon the extent to which Aboriginal people trust the dominant society. As illustrated in the excerpt below, Karen believes the reason why most Aboriginal people feel more comfortable in their own health care settings—as compared to mainstream ones—is because they have long distrusted the Western system and white people:

Karen: There's a huge long history of mistrust, and distrust, and so on, with the Western system and white people, so in that context, from my knowledge, it seems that most Aboriginal people are much more comfortable within their own health care setting, so I mean, that's all I can speak to.

Like Karen, Julie observed that Aboriginal people are not, at present, prepared to interact with white people and that more time will have to pass before their anxieties subside:

Julie: I think it would take a lot of work to get there, you know, the evolution of another generation to go through all the changes to reduce the anxieties around interacting with, you know, white people.

Blackbird is also under the impression that more time will have to pass before Aboriginal people, himself included, will be in a position to trust members of the dominant society. For certain, Blackbird's experience as an Aboriginal person living in Canada has been traumatic. At the age of five, he was taken away from his family and relocated to a hospital for Tuberculosis treatment for the duration of five years, after which he was relocated to residential school where he was often beaten for speaking his own language. As a result of these experiences, Blackbird is conscientious about keeping his identity as a medicine man hidden from members of the dominant society, including most health care providers when he treats patients in medical facilities. Blackbird also mentioned that he is disapproving of non-Aboriginals who use Aboriginal healing traditions to their advantage. For example, he told me about the time when a non-Aboriginal person dropped by his place of work to inquire about Elder Teachings. According to Blackbird, the reason why this person wanted to learn about Elder Teachings was because he wanted to secure additional funds for his own health organization; by claiming that he provided Elder Teachings, this person's organization would be eligible for Indian dollars.⁴⁰

Other Aboriginal participants in this study expressed concerns similar to Blackbird's. Leonard, for example, conveyed to me that some Aboriginal people do not want non-Aboriginals using their healing traditions:

⁴⁰ Indian Dollars refers to the body of funds allocated to Aboriginal peoples, programs, and organizations.

Leonard: We've got some guy, he's an Aboriginal man—he just got out of jail, and it's his third sweat in the community out of jail, and he comes in [the sweat lodge] and there's a white guy sitting across from him, and the white guy is just glowing he's so white, he's glowing in the dark and he's singing the songs and doing the drums and after the sweat the [Aboriginal] guy will say, "who does that white guy think he is?" "which guy?" "that white guy in there: Who does he think he is?"

The commoditization of Aboriginal healing traditions was both noted and frowned upon by Jeremy, a user of Aboriginal healing traditions whom I encountered at a healing circle. A minute or two after the circle came to a close Jeremy came over to talk with me about my research. He was keen to warn me about the dangers of sharing traditional medicinal knowledge with the rest society. "Aboriginal people don't much trust the rest of society", he said. He went on to tell me about a carpenter friend of his who had helped his boss by recommending a certain type of wood to use for building a particular outdoor structure. Shortly thereafter, Jeremy's friend was astounded to learn that his boss had patented the information he had disclosed. This is when Jeremy warned me about the risk of Aboriginal healing traditions being patented by large pharmaceutical companies.

Isabelle presented a rather distinct perspective on the use of Aboriginal healing traditions among non-Aboriginals. In the excerpt below, Isabelle is responding to a question about the use of Aboriginal healing traditions in integrative medical contexts where they would be accessible to all members of society:

Isabelle: Having it in a place where everything is brought together from all different peoples, that again, it's raising the awareness, it's sharing, I think that's a really important aspect. And yes, *there are some things that we keep that will not be shared*...if it was in another structure where there were non-Natives participating, they would never know that there was something that was not being shared as part of the rite.

Although Isabelle's perspective exemplifies the view that Aboriginal people distrust the dominant society, e.g., "there are some things that will not be shared", what

sets hers apart from other people's views on the matter is that she is not suggesting that Aboriginal people have to foster trust in the dominant society *prior* to bringing Aboriginal healing traditions into urban medical facilities. Instead, Isabelle is suggesting that Aboriginal people should be able to share however much information they want at their discretion which, in comparison to the others' perspectives, has unique and important implications: To withhold the use of Aboriginal healing traditions within urban medical facilities on the basis that Aboriginal people must first trust the dominant society is both limiting and denigrating because it means that Aboriginal people will not have the opportunity to determine for themselves when and how much information to divulge. Moreover, the very notion that Aboriginal healing traditions cannot be practiced in urban medical facilities *until* Aboriginal people foster trust in the dominant society borderlines a kind of "blame the victim" mentality—as if Aboriginal healing traditions would indeed be integrated *if only* Aboriginal people would stop being so mistrustful; as if it is their fault that Aboriginal healing traditions should not be integrated. In further support of this argument, consider the following question: How are Aboriginal people supposed to foster trust in the dominant society if they are not given the opportunity to do so?

5.5 There has to be an increase in Aboriginal health care providers

Both Leonard and Julie mentioned that the task of bringing Aboriginal healing traditions into urban biomedical facilities would be facilitated by an increase in Aboriginal health care providers. According to Leonard, Aboriginal health care providers have connections to healers in their communities and are thus in a position to arrange meetings for their patients:

Elena: So you're saying, even if it's just an Aboriginal nurse, that could be—

Leonard: That's the connection

Elena: That could be the connection? It doesn't have to be an Aboriginal healer? It doesn't have to be an Elder?

Leonard: She would have a base. You would have to get into the community, ok now here's the key to that: Let's just say there's a Stolo person or a West Coast Salish [person], she had one of their people in there, one of the long house people, and this lady there, let's say she's a Cree nurse, now she would have a list of people she would contact that would be pre-contacted before all of this was put in place and [she would] say, "would you be willing to come in".

This excerpt reveals that Leonard is under the impression that Aboriginal health care providers (nurses) are in a position to connect their patients with practitioners of Aboriginal healing traditions because they are connected to Aboriginal communities. Indeed, Leonard's views illustrate the kind of urban-reservation networking system that Reyna Ramirez's (2007) concept of the hub encompasses. Although Leonard does have a point, I do not believe that it can be applied to all urban-based Aboriginal health care providers. First of all, not all Aboriginal health care providers grow up in Aboriginal communities. Second, even those Aboriginal health care providers who may have at one point been connected to an Aboriginal community may have severed his or her ties upon leaving. And third, even if an Aboriginal health care provider is connected to an Aboriginal community, that community may be hundreds of miles away from the facility where he or she works, thus making it difficult for him or her to arrange a meeting.

Upon reflecting on Leonard's comment, I decided to ask Blackbird if the people who had invited him to work in hospitals were indeed Aboriginal health care providers. Here is the excerpt from my fieldnotes:

He says the health care providers who recommend his name to patients are not always Aboriginals, but he can see why some Aboriginals would think that

Aboriginal health care providers would be connected to healers (October 24, 2007).

I asked Smiling Stone as well and he said that the people who asked him to work in hospitals were typically the patients' family members, the hospital's chaplains, and other hospital workers who knew of his work through word of mouth.

Leonard made another interesting comment about the role Aboriginal health care providers would play in connecting Aboriginal patients with Aboriginal healing traditions. According to Leonard, Aboriginal patients feel more comfortable talking to Aboriginal health care providers:

Leonard: If you had an Aboriginal nurse that would be great because they [Aboriginal patients] will open up more to their own [kind].

In other words, Aboriginal patients are more likely to confide in Aboriginal health care providers about their interest in using Aboriginal healing traditions because they are Aboriginal. In the excerpt below, Leonard elaborates why this is so:

Leonard: If an Aboriginal person goes into any place where a lot of people go—that they have to go kind of thing—if you had an Aboriginal person sitting there, a Japanese person, an East Indian person, they'll wait for that Aboriginal person to be free, and they'll go [to them] as a rule. If they're in a hurry, ya anybody else is fine, but I'm just saying that there's not enough of that. I go to the prisons [and] *they'll tell me stuff that they wouldn't tell anybody else because they know I know.*

The correlation here is pretty straightforward: “Being” is “knowing”, and those of us who “know” through “being” can be trusted—experiential knowledge is trustworthy.

5.6 Discussion

Between sections 5.1 and 5.5 a number of arguments were posited: 1) the acceptance of Aboriginal healing traditions does not have to be predicated by scientific proof—it can be realized by being “open” to alternative views; 2) biomedical standards

are the default mode by which Aboriginal healing traditions are judged; and 3) it is limiting and denigrating to withhold the use of Aboriginal healing traditions in urban medical facilities until Aboriginal peoples trust non-Aboriginal people. Furthermore, a number of interesting assumptions were revealed, including: 1) there is a relationship between understanding and accepting; 2) Aboriginal health care providers are connected to their Aboriginal communities; and 3) experiential knowledge is trustworthy.

The participants discussed in sections 5.1 and 5.5 believe that the onus of bringing Aboriginal healing traditions into urban medical facilities falls onto: members of the dominant society (e.g. by accepting Aboriginal healing traditions or by recognizing Aboriginal healing traditions as efficacious); the biomedical establishment (e.g. by ensuring that physicians are open to alternative views or by increasing the numbers of Aboriginal health care providers⁴¹); and, Aboriginal people in general (e.g. by fostering trust in the dominant society). This set of perspectives is distinct from those discussed in the previous chapter because it treats the problem of integration as something to which everyone must tend, and overall the participants are conscious of the need to establish a situation in which Aboriginal healing traditions can be integrated with integrity. The last portion of this chapter illustrates participants' views on how they think these conditions should be met.

Although Susie, Blackbird, and Julie each noted a variety of reasons to explain why Aboriginal healing traditions are not ready to be integrated formally into urban medical facilities, they all believe that those reasons will be resolved over time. As shown

⁴¹ Although it was not articulated by the participants, I am aware that the biomedical establishment is not solely responsible for increasing the numbers of Aboriginal health care providers: The endeavour to do so depends as much upon the availability of government funds for training purposes as well as Aboriginal peoples' willingness to be health care providers in clinical settings.

in Blackbird's case, time lends itself to trust; it is *the* catalyst for shifting Aboriginal peoples' attitudes towards the dominant society, and in Julie's case, time lends itself to acceptance; it is *the* catalyst for shifting the dominant society's perception of Aboriginal healing traditions. Similarly, Susie mentioned to me during a telephone conversation that the process of informing society about the wrong doings done to Aboriginal peoples *takes time*. The topic came up a second time in an interview:

Susie: It's really important to teach society about the past doings and the wrong doings of what's happened through colonization [and] residential school issues for Aboriginal people. I think that's important too. But I don't think, you know, you could teach a class in a day or a week, you actually have to sit down and work with that individual and that's what I think you'll get from the Elders.

In Susie's case, then, time in and of itself is not the catalytic factor for broadening the dominant society's understanding of the wrong doings done to Aboriginal peoples. Rather, it is the time-consuming process by which the dominant society learns from Aboriginal people, face-to-face, on an individual basis.

Similarly, Isabelle commented that the way in which the Canadian government has sought to inform the dominant society about Aboriginal peoples (e.g. "book learning") has been unsuccessful:

Isabelle: Ok, what they've done in the past hasn't worked.

Elena: Exactly.

Isabelle: So (pause) you have especially (pause) I'm making reference to the RCMP training, the police, the City Police training, lawyers' training, even the teachers' training: All of it has been over the years, provided by non-Aboriginal people. It's all been book-learning and the successful formula is to have people who are Aboriginal, who have the experience, the life information of what it is they're talking about and the effects and impacts of everything the non-Aboriginal puts on paper and talks to the Indian Act, residential school, etc, etc., I mean it's meaningless: You get someone who comes in and says, "I'm third generation residential school, this is how it's impacted my family, my mother this, my sister this, and me, [and] my children now", you know, somebody that can tell a story

that people grasp meaning from it. ... I think we've missed the boat on the history lesson, you know: You want a history lesson, go to the history channel: You want to know how to work better with Aboriginal people then you talk to Aboriginal people, and have them share with you what it's all about being Aboriginal and living in Canada.

In essence, Isabelle is suggesting that members of the dominant society will be in a position to "grasp" how Aboriginal peoples have suffered if they receive information directly from Aboriginal people in emotionally impressive and/or transformative ways. In other words, according to Isabelle, emotive (as opposed to cognitive) understanding is what propels the rest of society to work better with Aboriginal people.

Along the same lines, Susie is under the impression that society will have more compassion for Aboriginal peoples if they understand the wrong doings done to them by either spending time with an Elder (as noted earlier) or learning this information on their own, as noted below:

Susie: I think if society actually just educates themselves on some of the wrong doings then they would have a little more compassion and a little more patience with those individuals or those situations that become heated.

True enough, neither Isabelle nor Susie specifically say, "emotional understanding brings about a change in the dominant society's perception of Aboriginal peoples", however it is obvious that they believe personal, heartrending information helps to create the empathy needed for people to act and/or respond with compassion.

That emotions influence the way people act is a concept known to the anthropology of the body. In Lock and Scheper-Hughes' landmark article "The mindful body: A prolegomenon to future work in medical anthropology" (1987), it is posited that emotions are the mediatrix of the Three Bodies—the Individual Body, the Social Body, and the Body Politic (p. 28). Drawing upon the work of John Blacking (1977), Lock &

Scheper-Hughes argue “emotions are the catalyst that transforms knowledge into human understanding and that brings intensity and commitment to human action” (p. 29). Likewise, Lyon & Barbalet (1994) who write from the vantage point of the anthropology of embodiment have argued that emotion functions as the basis of agency; that it “activates distinct dispositions, postures and movements which are not only attitudinal but also physical, involving the way in which individual bodies together with others articulate a common purpose, design, or order” (p. 48). Although Lyon & Barbalet acknowledge that “the link between emotion and action is complex and certainly not mechanical” (p. 57), they argue for certain, “emotion is socially efficacious”—that is, it has social consequences.

In contrast to the theories of emotion/action posited here, I would like to stress that it is possible to be moved—in the emotional sense—and not act. In other words, even if Aboriginal people are successful at *emotionally impressing* members of the dominant society, members of the dominant society are not necessarily going to treat Aboriginal people with more compassion. For example, I do not always give money to homeless people who plant themselves on the sidewalk even though I feel upset about the situation they are in. I am emotionally *impressed* but the sensation does not propel me to act—to give money, food, or shelter. Sometimes I give a smile, but not always.

Without making reference to emotionally impressive means of understanding, Jay’s comments are comparable to Isabelle’s and Susie’s insofar as he believes that socio-political information is necessary for understanding and helping his patients:

Jay: Basically, you know, again it goes back to someone and where they’re coming from, and where they’re coming from is their culture, is their history, not only their personal history but their collective history, the history of their people, of their tribe, and that could be a tribe of an Aboriginal or a tribe of the [Jay] clan,

and what my ancestors have gone through, so that might carry with me, that's part of who I am, so if somebody's going to help me to heal, they have to understand my context, my history, my ancestry, my culture and my present situation.

Jay: What's my past, what's my history, where am I right now, and what are my dreams, where do I want to go? If you understand me in that entirety, then you can help me heal. If you don't understand where I come from and where my people come from and what my socio-political context is, and my culture, and my present circumstance, and you just treat me like I'm any other person that's come through your door, you can't really help me help myself right?

Like Jay and Susie, Karen feels that socio-political information is a tool for deepening understanding. In the excerpt below, Karen is responding to my question about the value of socio-political information as compared to culture-specific information:

Karen: I think it's great, I don't know if it has to be an either/or thing.

Elena: Ok, so another—

Karen: Tool, I think it's a way of deepening—

Elena: Understanding?

Karen: The understanding, absolutely.

Crystal feels that health care providers would be able to grasp and understand socio-political information more than culture-specific information:

Elena: Rather than knowing culture-specific information [what do you think about] knowing socio-political information [e.g.] residential schools were open until 1986 ...I just wanted to know what you thought about that idea?

Crystal: Ya, I know that that would, maybe that would be easier because as you say each tribe has so many different variables, how do you reach, you know, I don't know how you could learn it all.

Sally, however, was the only participant under the impression that socio-political information might lead to preferential treatment:

Sally: Some background information certainly helps you care for them [patients] and helps you understand where they're coming from *as long as it doesn't preempt different treatment that otherwise they wouldn't be getting.*

Along the same lines as Susie and Isabelle—who believe that the dominant society will have more compassion for Aboriginal peoples if they understand what they have been through—Crystal, Julie, and Sally believe that health care providers cannot be culturally sensitive towards Aboriginal people without an understanding of Aboriginal culture. According to Crystal:

Crystal: It's been a problem for years: Like how do we provide culturally sensitive care? *And we can't really because they [the physicians] don't know enough about it.*

In the excerpt below, Julie is explaining how she would go about making the medical facility where she works more appropriate for Aboriginal patients:

Julie: *First we would probably need some education.* We do have a lot of Native or Aboriginal clients here and I'm not sure whether anybody's gotten any education about approach or style or sensitivities or anything like that so I think that would probably be the first thing that we would have to do. And then, depending on what the information was that we got from that, how we might apply it to our practice.

Below, Sally explains that because she does not understand what Aboriginal healing traditions are all about (she does not know what they mean), she cannot accept them:

Sally: Because I don't know what it means, like it doesn't mean anything to me but *maybe if I learnt about it and felt a connection with it then ya, but at this point I don't know very much about it or if someone was doing smoking things in my room I'd probably cough and tell them to leave.*

Apparently, Louise feels the same as Sally:

Louise: What do we know about Aboriginal healing? Like nothing right, so you know, *that might be a preceding piece that could happen is some education around that so that people are a little bit more aware and then the acceptance level might be better or the interest in it might be better.*

The fact that Crystal, Julie, and Sally believe knowledge about Aboriginal cultures is necessary to cultivate sensitivity towards Aboriginal patients is inextricably linked to the

concept of cultural competence. In other words, it is the belief of these health administrators that sensitivity towards Aboriginal peoples and their healing traditions cannot be realized unless they are *competent* in Aboriginal culture. Sure enough, all of the health administrators who helped to inform this study are familiar with either cultural competence or cultural sensitivity.⁴² Five of them validate the concept(s) explicitly.

According to Sally:

Sally: Well ya, I mean, I think it's a great thing. I think that there's, like, little practices that people do, like, I think it's the Chinese people that don't want to have their head exposed because they feel that all the heat's going to escape and they're going to be cold, they also don't want to wash in the hospital, they feel that there will be, I think it's they're more susceptible to getting stuff, but it's just not the right place to wash, so those kinds of ideas, like for us, we may see them as totally different *so if there is more knowledge surrounding people's practices, then maybe ya, maybe it would really would help us out.*

In the excerpt below, Julie is expressing the view that information pertaining to cultural competence is easy to forget because it is delivered infrequently in small, superficial doses. In spite of that, she believes that training in cultural competence is an important issue:

Julie: I finished my (degree) in 2002, and in that last couple of years there was a lot of discussion about cultural competence and understanding each other and, you know, I mean some of the basic things like: (pause) *isn't that awful I don't even remember* (pause) don't stare, you know, don't look directly into someone's eyes [and] because I was working in mental health, I think I learnt a little bit more about that but nothing, nothing really in depth so that they are too easy to forget, which I do, I forget.

Elena: Nothing too in depth? Ok—

Julie: Which makes it easy to forget, right. If you only learn a little bit, you only remember a little bit; that's just sort of the human, that's just the way we are, kind of sort of thing. So if you don't get it in any great depth amount, then you're not

⁴² Culturally *sensitive* health care is a predecessor of culturally competent health care. Culturally sensitive health care is strictly concerned with educating health care providers about cross-cultural health related beliefs and behaviors.

going to remember hardly anything unless you're immersed in it all the time and you're not, especially as a manager, unless it's something that's coming up regularly, or you take a conscious effort to focus on it, then just in the busyness of the day then you are not going to, it just doesn't happen unfortunately. I mean it's good when it does, I mean that was good, *it was a great day when the hospital decided to take that on because we needed them to identify it as an important issue*⁴³.

According to Crystal, cultural competence is, straight and simple, a “no-brainer”:

Elena: I'm just wondering if you've ever come across the notion of culturally competent health care?

Crystal: It's been talked about. It's just a no-brainer

Elena: A no-brainer?

Crystal: It's a no-brainer.

Denver is supportive of cultural competence but not in the conventional sense. According to him, the concept is useful because it broadens our understanding of health and medicine, not because it predisposes cultural competence, nor because it helps to facilitate the flow of biomedical care to minority populations:

Denver: Ah, it is a concept that I have encountered. One of the aspects of our work is to bring into medicine an understanding of health and illness that is broader than the historic biomedical model, so it is a concept that I'm familiar with and that I support.

Karen, too, is under the impression that cultural competence is an important issue. In fact, she goes so far as to say that it is dangerous for health care providers to trust what their ethnic minority patients tell them without prior culture-related background information:

Karen: People do tend to kind of jump over that piece of, “ok, then I don't need any knowledge if I'm going to be stereotyping people then. I don't really need knowledge: All I need to do is ask an individual what their preferences are”. But there's danger in that: It's absolutely true that you can't know all the patients, what their expectations and beliefs are without asking them. *It's also very true*

⁴³ Julie is referring to a workshop on cultural diversity that she attended while working as a nurse at a hospital.

that without understanding what someone's cultural patterns are, you're going to be totally blind, oblivious to some of the things you need to ask about.

In the preceding few pages, I have illustrated the various ways in which participants validate cultural competence. In the examples that follow, I seek to show the various ways in which participants interpret and enact this concept.

In the excerpt below, Jay conceptualizes cultural competence in terms of *human* competence:

Jay: The way my brain works it's just very much heart-centered so when I approach healing I'm thinking about cultural competency: I'm thinking about the person or people in front of me and how they are humans just as I am a human, how they have struggles just as I have struggles, how they have different ways of seeing things and approaching things because of their own contexts.

Karen, on the other hand, conceptualizes cultural competence as the process by which health care providers integrate "pieces of information" into their practice:

Karen: Over the next year what we hope to do is, or what I hope to do is, work with the different practice groups as a group and *teach pieces of information* and then have them use it, to go to their assessment tools and say, "how can we deepen our understanding of what's important cross culturally" by adding new questions, essentially looking at the tools and see how, what the Western assumptions are and how can we make them more culturally appropriate, *so essentially try to embed it into the practice rather than keep it as a piece of knowledge.*

In other words, cultural competence is the process by which information-based resources are practically embedded and/or enacted. Julie's interpretation is comparable to Karen's:

Julie: You still need the education, but then you need to do something with it, otherwise you don't remember it, right, so depending on what we learnt at the course, then we would need to figure out, you know, *we would have to have a working committee to think about how we are going to take that information and apply it on top of a practice, you know, how we are going to build it into the clinic.*

Because Louise was not familiar with the term “cultural competence”, I asked her to share her understanding of cultural sensitivity:

Elena: What’s your understanding of cultural sensitivity I’m curious?

Louise: Having a multi-cultural work force within your organization so that you’re not just saying, “oh ya we’re culturally sensitive” but you actually demonstrate that you are accessible by having a variety of people from different cultures working in your organization who can assist each other to understand cultural differences so you have that sort of internal organization focus as well.

Evidently, Louise believes that culturally sensitive health care is achieved by having a multi-cultural work force. In her opinion, multi-cultural staff members educate one another about their people’s ways.

Distinct from Leonard’s suggestion for an increase in the number of Aboriginal health care providers as a means to connect Aboriginal patients with practitioners of AHT, Louise’s rationale behind establishing a multicultural workforce is not to facilitate the use of Aboriginal healing traditions (or other cross-cultural healing modalities for that matter), but rather to educate other staff so that they have a better understanding of the minority patients they serve. On one hand, I think this illustrates the “one-way-ness” of cultural competence: Information about minority cultures is imparted to health care providers but information about health care culture is not imparted to minority patients (or *any* patients for that matter). On the other hand, I think this goes to show that Louise believes cultural competence is most effectively enacted by way of experiential knowledge: To *be* a member of an ethnic minority group is the best way to be competent of it; it is cultural competence par excellence. Here, then, it can be said that this non-Aboriginal health administrator’s views about knowledge (the value of experiential

knowledge) are comparable to the views of Aboriginal health administrators Isabelle, Susie, and Leonard.

To bring this chapter to a close, I offer a brief summary. Time, personal experience, and cultural competence—these are the means through which participants believe that trust and understanding are fostered. While participants' views differ in this respect, they commonly believe that *understanding* is the mechanism that brings about a change of heart. Whether this is actually the case is another story. I have argued that understanding does not necessarily cause one to act. However, I do believe that if experiential knowledge is “what works best” (according to some of the participants in this study) then I support it as a means for the transfer and acquisition of cultural knowledge in health care contexts. As for the concept of cultural competence, participants both conceptualize and enact it in multiple ways. More specifically, participants conceptualize the concept as an educational endeavour—something that has to be learned and integrated; an empathetic endeavour—something that is achieved by understanding where someone is coming from; and an experiential endeavour—something that is accomplished by hiring a multi-ethnic work force.

Chapter Six

Participants Views: Aboriginal healing traditions should not be integrated into urban medical facilities

As noted in Chapter 3, the task of bringing Aboriginal healing traditions into urban medical facilities faces historical/political, practical, and philosophical challenges. Although participants did point to these challenges (among others), those who were genuinely opposed to integration pointed to various components of biomedicine as the chief inhibitor. In this chapter, I present participants' views on those aspects of biomedicine that would significantly hinder the integration of Aboriginal healing traditions into urban medical facilities, including: 1) biomedical environments are not conducive to conversation—a central aspect of Aboriginal healing traditions; 2) Aboriginal healing traditions have to get a foothold without having to deal with biomedical paradigmatic constraints; and 3) Aboriginal healing traditions take time—the health care delivery system would have that process speed up.

6.1 Biomedical environments are not conducive to conversation—a central aspect of Aboriginal healing traditions

According to Ellen, Aboriginal healing traditions should be delivered in environments that are conducive to conversation and, unfortunately, medical facilities (e.g. hospitals) are not:

Ellen: Well in terms of the facility, I would say that it's too cold, too, you know, uninviting to have that conversation ...you just sit like a lump waiting for your turn to see the doctor and I mean they do try to make it reasonably hospitable but you know it's a big grey concrete building and I just don't find it welcoming at all, and certainly not for the kind of conversation I would have with [Smiling Stone] or my psychologist.

Ellen: I don't think I would feel comfortable in a green walled medical room in a hospital talking to him [Smiling Stone], no. I would want him to take me out of

there. I really don't think hospitals are good for opening minds or that they're very conducive to encouraging spirit. I just don't think they're built like that, they're so, they're so allergic to those ideas themselves, they're built into the walls, it's part of the atmosphere, skeptics floating around who just really don't endorse it.

Ellen's reason for believing that Aboriginal healing traditions should not be integrated into urban medical facilities points to a practical incongruity between the two systems: The quality of space in which both systems deliver care. True, lots of medical facilities fit the picture Ellen paints—cold, green walls, grey concrete—however I do not believe this description characterizes all medical facilities across Canada. It is not impossible to find a hospital in which “natural” colors and lighting replace the more traditional white or green walls and fluorescent lights. In fact, over the last fifteen years, the movement towards patient-centered care has sparked a shift in health care architecture. One can find, for example, an article devoted to healing by design in *The New England Journal of Medicine*. According to Horsburgh (1995):

Medical care cannot be separated from the building in which it is delivered. The quality of space in such buildings affects the outcome of medical care, and architectural design is thus an important part of the healing process (p. 735).

In the *Journal of Health Facilities Management*, Malkin (1993) notes “healing can be promoted by surroundings that reduce stress and engage the senses in therapeutic ways”, but that change is not limited to “superficial renovations relating to finishes and color”, it can also be accomplished by asking: “What are the stressors in this environment? How can they be reduced or eliminated? How can we affect the minds of the patients, unleashing their own senses to promote healing?” (p. 18). Malkin lists music, film, literature, and laughter therapy as non-physical ways to promote healing. As rooted in

Euro-centric attitudes and beliefs about health and healing as these suggestions may be,⁴⁴ they nonetheless suggest that Ellen could potentially find a space within a medical facility where she and Smiling Stone could converse comfortably. The other concern of Ellen's is finding a medical facility void of "skeptics" who do not endorse Aboriginal healing traditions. This too is not impossible. As evidenced by Jay and Denver's comments in previous sections, it is possible to find health care providers and/or administrators who are open to alternative views. The challenge remains, however, finding a medical facility where both physical *and* philosophical atmospheres are satisfactory.

6.2 Aboriginal healing traditions have to get a foothold without having to deal with biomedical paradigmatic constraints

In the previous section it is obvious that Ellen feels biomedical environments, (the quality of the facilities and the attitudes upheld by the people who run them) are inhospitable and, overall, not conducive to the kind of environment in which Aboriginal healing traditions should be administered. Indeed, it is obvious Ellen feels that medical environments detract from Aboriginal healing traditions, however, Blackbird was the only participant to note this explicitly. Below is an excerpt from my fieldnotes in which I describe Blackbird's attitude towards integration:

I asked him about integrating Aboriginal healing practices into urban medical facilities and he said that it's important for Aboriginal doctoring to be practiced in isolation from Western medicine. It really needs some space to recharge. Western medicine would pollute it; detract from it. It needs to get a foothold (July 05, 2007).

⁴⁴ Malkin does not consider that spiritual engagement may activate healing. Instead, she attributes healing to mental engagement. Moreover, Malkin assumes that healing arises as a result of engaging humans' sensorial faculties—she does not consider that healing might also be activated by engaging *spirits'* sensorial faculties who, in turn, assist in healing the patient.

In the excerpt below, I explain why Blackbird thinks Aboriginal healing traditions have fallen behind and have to catch up:

Because of European colonization and assimilation First Nations people have lost a lot of traditional medicinal knowledge. Even if he is capable of determining that one man's cancer is caused by the spirit of a bird, he can't say exactly which bird and therefore he cannot approach that bird's spirit family to ask for help. Knowing which type of bird is crucial for treatment (July 05, 2007).

He says that he's tried to heal cancer but that he's not ready. The Aboriginal people are 100 years behind and the Creator won't give them the power they should be able to have. He said he knows what cancer is but that Aboriginal healers are not ready to treat it (June 07, 2007).

To be clear, Blackbird believes that colonization has impaired traditional medicinal knowledge and, to protect whatever knowledge is left, Aboriginal healing traditions should not "mix" with Western medicine. Given that Western medicine is the dominant society's medicine of choice—or at least it is the status quo—it is not difficult to see Blackbird's point: He is fearful that the same unequal relation of power between Aboriginal and non-Aboriginal society is manifested in the medical system;⁴⁵ he is fearful that if Aboriginal healing traditions are employed in medical facilities they will be at the mercy of biomedical paradigmatic constraints. Louise's comments illustrate this issue further:

Louise: There would be real barriers to bringing it [Aboriginal healing traditions] into a medical clinic, and if I were responsible for setting it up, I'd rather do my own thing, you know, a private society, then you've got more control and more autonomy to set it up the way it needs to be done ...*here I think the barriers would be substantial in that physicians have a lot of power ...there's individual physicians that are really open to alternative types of approaches and then there are those that aren't and would see that as a real, you know, that it would affect medical care.*

⁴⁵ See further Michael Taussig (1987) for a discussion on Indigenous medicine as a form of resistance against colonialism.

Blackbird and Louise's comments illustrate Hill (2003) and Benoit et al.'s (2003) observations with respect to Elders' concerns about government control over Indigenous medicine. As a medical system whose autonomy and control was historically systematically stripped and whose knowledge and practices are currently behind "100 years", bringing Aboriginal healing traditions into urban medical facilities—where biomedical care is the number one priority and physicians are credited with more power than everyone else—would only hinder AHT practitioners efforts to regain balance, knowledge, and autonomy.

Blackbird's aversion to mixing Aboriginal and Western medicine based on his assertion that Aboriginal healing traditions are "100 years behind" does not represent the views of all AHT practitioners. Some are indeed willing and ready to use their healing traditions in spite of historical, systematic oppression. Smiling Stone is one such example. One of Smiling Stone's core philosophies is "always help people when they ask for it":

Smiling Stone: I was taught to be a good relative⁴⁶ to help people when they're asking for help because it's a very small window that people will accept it. They say, "To heck with this" and don't take the help that they need to change their lives and then continue to spiral down the tubes. So I always try to be there for them when somebody asks for help; to be there when they need me whether it's in the institution or in the hospital.

And, unlike Blackbird who believes that the Creator will not give Aboriginal people the power to treat cancer because they lack key information about the spirit world, Smiling Stone has established a relationship with the Creator who, in turn, has revealed the "essence" of cancer as well as treatment options. According to Smiling Stone, cancer is comparable to spores: Just as spores float about the air, germinating independently

⁴⁶ Smiling Stone refers to all people as "relatives".

wherever they settle, cancer cells float about the body, reproducing in a similar fashion.

For this reason, the sweat lodge is useful in helping the body to eliminate cancer cells.

Here is an excerpt from my fieldnotes:

Smiling Stone said that the Creator told him that sweats are crucial for health—especially for cancer—the skin is a giant organ to help the liver and kidneys get rid of all the cancer cells. It's better to help the liver and kidneys to eliminate as many cancer bodies as possible (May 30, 2007).

He also uses the sweat lodge and sacred pipe to uncover therapeutic options for his patients:

Smiling Stone: If somebody comes with an illness I will go into the sweat lodge and I will sit there with the pipe and ask “how can I help the person”, what type of, I guess you could say, “what type of treatment would this person benefit from the most”, and then I would get my answer [from the Creator] in the lodge.

I was curious to know what Smiling Stone might do if, for some reason, he did not have access to the sweat lodge and other tools to summon spiritual guidance:

Elena: It makes me think: if you don't have a pipe, or tobacco, or a sweat lodge: if you don't have those places and those tools to sort of figure out what's happening—what needs to be done and how to proceed—can you proceed?

Smiling Stone: Yes

Elena: Do you need to have all those—

Smiling Stone: What I've done is—in cases like that when I've been somewhere and I don't have my stuff with me—I'll sing some of the healing songs and he'll give me the answer.

As it appears, not only do Blackbird and Smiling Stone's views diverge with respect to the relative “strength” or “readiness” of Aboriginal healing traditions to endure a situation in which Aboriginal and Western medicine are mixed, but they diverge with

respect to cancer etiologies and treatment options:⁴⁷ Recall, according to Blackbird, the incidence of cancer is traceable to meddling spirits whose family members are the only ones capable of dissuading them from their mischief. For Smiling Stone, however, the incidence of cancer is traceable to a palpable, spore-like entity within the body that is expellable through the skin by way of participating in sweats.

Interestingly, although supernatural power is fundamental to Blackbird and Smiling Stone's healing traditions, they mobilize it in different ways. Smiling Stone, on the one hand, invokes the Creator to ascertain which therapies patients will benefit from the most (e.g. the sweat lodge), yet it is the patient who by participating in those therapies mobilizes his or her body's own cleansing mechanism (sweating) to heal itself. For Blackbird, on the other hand, spiritual power is *the* measure by which therapeutic efficacy is mobilized. For example, according to Blackbird, medicinal plants and herbs are healing because of the potency of their spirits, not because of their chemical and/or nutritional constituents. In other words, to hold sage in one's hand is to be in close proximity to potent spiritual power, and this, in effect, is health-giving; one need not manipulate its physical form (e.g. make tea from it) to access or "unleash" its therapeutic potential. Along the same lines, Blackbird believes that children have more healing power than adults because they (their spirits) are closer to the Creator. One day in August (2007) he told me specifically: Children are important to have around because they have that healing power. But in hospitals, they always want the little children out.

Likewise, in all the time that Blackbird has been practicing Aboriginal healing traditions—about twenty years—he has never been allowed to burn sage in medical

⁴⁷ Blackbird and Smiling Stone come from different Aboriginal cultures and share different worldviews pertaining to health and illness. As a measure to protect their identities, I do not reveal the names of the particular tribes to which they belong.

facilities. One evening in July (2007), Blackbird and I ate dinner together and I asked him how he got around that: “If you can’t burn sage in the hospital how do you purify the rooms?” In response, Blackbird reached for his black binder—filled to the brim with Elder Teachings⁴⁸—and drew out an eagle feather. He said, “I use this instead”. Here again, Blackbird is referring to the spiritual potency of the eagle feather.

Blackbird and Smiling Stone do share similar thoughts on the biomedical paradigm in spite of their distinctive views on therapeutic efficacy and the etiology of disease. For example, they both feel that physicians disapprove of them. According to Blackbird, physicians do not want him around because “they want to have all the authority”. Here is an excerpt from my fieldnotes:

When he goes into the hospitals the doctors don’t want him there. He says that they want to have all the authority and they tell their patients: “Why do you want to talk to *him*?” (June 07, 2007).

Likewise, Smiling Stone feels that physicians have a problem with him because he lacks formal (biomedical) training. He has a hunch that this might also have to do with his *un*-insurability:

Elena: Some of the things that you do, like the drumming and burning, I’m just wondering about bringing them into hospitals and medical clinics and different places where there are other patients and other medical doctors?

Smiling Stone: See, I don’t have myself, personally, I don’t have a problem with that, *they usually have a problem with me*, because they went to school for so many years, they’re pretty much insured if they make any mistakes. They’d be more concerned with an Aboriginal person in there, a traditional healer, because (pause) maybe liability.

Smiling Stone’s presence (as an AHT practitioner) is not always seen as “a problem” in biomedical contexts, in fact health administrators have requested his services on more than one occasion. However, the circumstances under which he and his trade are typically

⁴⁸ Elder Teachings are anonymous publications of collective Aboriginal wisdom

tolerated are stifling. For example, one individual called him up to see if he would put forth an application to an up-and-coming integrative medical center aimed at Aboriginal people.⁴⁹ When Smiling Stone asked how they would select an Elder for the position, the individual said, “the physicians get to decide.” Smiling Stone was disappointed to hear that the only tradition he would be allowed to practice was smudging. When he asked the individual why he would not be able to practice anything more, he was told: “it’s a liability thing; doctors have insurance, Elders don’t”. The center was also planning to advertise the position at \$65,000.00 per year, which, according to Smiling Stone, is problematic: Truly qualified Elders are willing to work voluntarily. This is not to say, however, that Smiling Stone would not expect *some* compensation for sitting in an office all day, but simply that they should reconsider how they advertise the position—at \$65,000.00 per year, they are going to get a lot of applicants who are not in it for the “right” reasons.

On another occasion, the president of a large medical institution asked him if he would be an “on-call” Elder. Apparently, the president told him, “Aboriginal patients don’t want to talk to our physicians; they won’t tell them how they are doing or feeling—things like that”. Smiling Stone went on to qualify what the president was talking about. He told me that many Aboriginal patients see their doctors as cold, grim reaper types. In a sense, Smiling Stone shares this view. He believes that doctors prescribe treatments unknowingly and do not improve upon their techniques when improvement is due:

Smiling Stone: I’ve seen doctors say, “take this and see what it does and then come back in a couple of weeks and if it doesn’t work we’ll give you something else” and I go, “oh, jeeze”... We [medicine men] keep what works and scrap what don’t work and a lot of them [doctors] just seem to keep everything—they keep what don’t work.

⁴⁹ This facility has yet to be established.

Below, I describe Smiling Stone's perception of the biomedical environment, which, according to him, is comparable to a place of punishment.⁵⁰

He made a comment about the nature of medical environments: It's quiet, there's no noise, and no smells. He likened the environment to one that children experience when they are being punished. It's kind of like when parents say "go to your room"—and sit there in isolation kind of thing—there's no sense of living people around you doing real live things; no cooking, no singing, no drumming, no making the sounds of life (May 30, 2007).

Along the same lines, Denver described the biomedical environment in equally dreary terms:

Denver: the kind of environment that supports healing typically has earth colors or nurturing colors; has aspects of reflections of nature within them; has lots of natural light and ...all of those things can play a roll in the physical environment that is nurturing and soothing. It's interesting that at least recently, in the last hundred years, conventional medicine seems to have not valued as greatly those components of care, and glaring lights, white sterile rooms, septic or antiseptic smells actually do the opposite: They create an environment that physically starts to close down the opening that is important for healing.

Likewise, Denver believes the health care system is lacking in "human competence":

Denver: Although I think it is important to have cultural sensitivity and cultural competence, it's more important to have human competence and that's what's lacking in our health care system right now. I would prefer a medical system that has human competence than just simply a medical system that has cultural competence in a superficial sense because it's not really about the treatments, it's not really about the artifacts that we use—it's about the experience of treating each individual in a humanly dignified way so that their illness experience has meaning for them and to honor that.

According to Denver, the concept of sensory-friendly facilities is a wonderful idea and "is really what's needed":

Denver: I think that is a wonderful idea, I think that is really what's needed and I would include other essential aspects of creating an optimal healing environment in that—I think what you're saying, for me at least, what that says is that—what might be better or more optimal or more valuable to a broader range of people, in

⁵⁰ Smiling Stone's description of the biomedical environment is relatable to Foucault's (1975) premise of "biopower".

fact all of us, is to create health care organizations that create an optimal healing environment, and that healing environment is both physical and non-physical and some of the sensory aspects help to support the creation of the physical healing environment and there are other aspects of care that help to support the non-physical optimal healing environment and that includes respect and the honoring of people's individual journey's.

Although the philosophical tenets upheld by Denver and the center where he works are not specific to Aboriginal peoples, Aboriginal people have reported that the center's programs are consistent with their ancestral views on health and healing:

Denver: Well the feedback that we got was that they felt as though our programs were consistent with their ancestral traditional views on health and healing—they weren't presented as a First Nations' experiences but that they were consistent with that experience—*so honoring the individual; honoring the spirit, honoring the right to choose*; and honoring the spiritual journey that we're all on. So the feedback was very positive in the sense that although it wasn't culturally specific, it was culturally meaningful.

Although Denver has had limited experience being with First Nations people, one of the things he really appreciates is that "they tend to have an understanding that the mind and what they know in their mind is not the important thing: What they know in their heart is the important thing".

Unlike Smiling Stone and Denver, Blackbird is not as critical of health care providers (the way they care for patients or the medicine they practice) or the biomedical environment (atmosphere, physical characteristics) but he is very distrustful of the dominant society and very, very secretive about his work as an AHT practitioner. For example, when academics ask him to share his traditional knowledge with students, he always refuses. Here is an excerpt from my fieldnotes:

He said something like, "I didn't want to get involved with that. They have too much paper work. It's too much confusion. We don't use these books (he touched a newspaper) to teach our traditions. This is too much publicity. We don't advertise. We are very careful with our information. We don't trust the dominant society. Potlatches were illegal and so was the sweat lodge" (June 08, 2007).

This section takes as its point of departure Blackbird's views on the use of Aboriginal healing traditions within urban medical facilities. Blackbird believes that colonization has impaired Aboriginal healing traditions and, therefore, in this weakened state, Aboriginal healing traditions should not mix with Western medicine because of the unequal power differential between physicians and practitioners of AHT. In other words, the use of Aboriginal healing traditions within urban medical facilities would only exacerbate the already unequal power relations between Aboriginal peoples and the Canadian state. Put simply, the power of physicians (relative to AHT practitioners) is a biomedical paradigmatic constraint that Blackbird is not willing to entertain. From this point, I proceeded to argue that Blackbird's views are not representative of all AHT practitioners. Smiling Stone, for example, is willing to treat anyone who asks for help. Indeed, the suggestion that Aboriginal healing traditions are "weak" is subjective and will most likely be influenced by practitioners' personal experience with the Canadian state. This might explain why Blackbird is so untrusting of the dominant society: As an individual in his early seventies, Blackbird has memories of a time in his life when Aboriginal spirituality was illegal. He recalls, for example, taking part in secret sweat lodge ceremonies when he was a boy. His views about integration are thus influenced by this experience, not to mention his traumatic residential schooling experience.

Following this, I illustrated the philosophical and practical underpinnings of Smiling Stone and Blackbird's healing traditions, which revealed the diversity within the category "AHT practitioners". Recall, for example, Smiling Stone and Blackbird mobilize spiritual power in different ways and for different reasons.

That Smiling Stone and Blackbird feel physicians disapprove of them (Blackbird more so than Smiling Stone) possibly stems from their *un*-insurability. Although liability is not exactly a biomedical paradigmatic constraint (liability is an artifact of Canada's larger political framework) it is a standard of and integral to Canada's health care delivery system. Furthermore, that physicians disapprove of AHT practitioners (specifically those AHT practitioners who offer their services in medical contexts) possibly relates to their position of power: Some physicians may perceive the presence of AHT practitioners as a threat to their authority. I remind you of Louise's comment: "they would feel very much that their toes are being stepped on". On the other hand, that physicians disapprove of AHT practitioners may very well stem from their *personal beliefs* about Aboriginal healing traditions and AHT practitioners. After all, physicians are not just members of health care culture, they are members of the larger Canadian society, and given that Aboriginal healing traditions are neither accepted by the dominant society nor recognized as efficacious, they may have adopted these views.

In the last portion of this section I illustrated Smiling Stone and Denver's attitudes towards biomedicine. What deserves mention here is how these two categorically distinct participants (a non-Aboriginal health administrator and an Aboriginal AHT practitioner) share similar views about the limitations of our current health care system and similar understandings of health and illness. Finally, it is important to note, Denver's views pertaining to sensorial dimensions of healing do not seem to affect his views pertaining to the use of Aboriginal healing traditions within urban medical facilities. Rather, his views pertaining to sensorial dimensions of healing seem to be affected by his willingness to relinquish the biomedical paradigm. In other words, because the medical paradigm to

which Denver adheres is much broader than the biomedical paradigmatic alone, he can fathom sensorial dimension of healing as a component of health care.

I now turn to the challenge “Aboriginal healing traditions take time—the health care delivery framework would have that process speed up”—yet another reason why some of the participants in this study believe that Aboriginal healing traditions should not be integrated into urban medical facilities.

6.3 Aboriginal healing traditions take time—the health care delivery framework would have that process speed up

Blackbird was the only participant to explicitly state that Aboriginal healing traditions should not be integrated into urban medical facilities because they take time—that is, more time than they would be granted within conventional health care delivery frameworks. Louise’s comments speak to this issue:

Louise: On a bad-case scenario, they [patients] would have to wait for three or four hours to see a physician and then they’re done, so we’re not caring for somebody here that is ill and is bed-ridden where family would want to come in and spend time. It just doesn’t really happen here and that might be why we don’t get that kind of a request [Elder services].

Although Louise does not say, “Aboriginal healing traditions should not be integrated into urban medical facilities because they take too long” she is under the impression that Aboriginal healing traditions are not administrable within standard appointment timeframes. According to Blackbird, Louise’s impression of Aboriginal healing traditions is right on track. I offer an excerpt from my fieldnotes:

Elders need a lot of time to prepare, to figure out what the problem is and to find the best language to describe what the problem is (August 3, 2007).

To give you a sense of how much time AHT practitioners may need to diagnose an illness, consider Smiling Stone’s comments:

Smiling Stone: Sometimes if somebody comes with an illness I will go into the sweat lodge and I will sit there with the pipe and ask how can I help the person—what type of treatment would this person benefit by the most—and then I would get my answer in the lodge and then I would sit with them [the patient] ... and then we'd smoke the pipe together because in our way when we smoke the pipe what I'm telling you is true, I can't lie to you with the pipe and so you would know that what I'm going to tell you—"I'm serious" right, and I would say "this is what they [the spirits] said that you need to do" and it would be up to you to decide if you would want to do that or not.

In the excerpt above, Smiling Stone discusses one of the processes by which he diagnoses illness; a process that entails the use of a sweat lodge and a sacred pipe; a process that requires at least a couple of hours not including the time it takes to construct a sweat lodge (which need not be done very often) and a fire to heat the hot rocks. Indeed, the diagnosis process alone (using the methods cited above) would be impossible to accomplish within conventional medical appointment timeframes (30 minutes maximum). However, one should not assume that because the sweat lodge - sacred pipe combination cannot fit within conventional medical appointment timeframes that all Aboriginal healing traditions also cannot fit. Recall, when Blackbird purifies hospital rooms, he uses an eagle feather, which takes even less time than does smudging. Smiling Stone too said that he sings sacred songs when he does not have access to a sweat lodge or a sacred pipe. But, then again, *why must Aboriginal healing traditions fit into conventional health care delivery timeframes?* Indeed, the integration of Aboriginal healing traditions into urban medical facilities may very well require Blackbird's practice to speed up, and this is a biomedical paradigmatic constraint to which he will not abide.

6.4 Discussion

Insofar as Ellen's concerns go—finding a medical facility where the atmosphere is both physically and philosophically conducive to Aboriginal healing traditions—I have

argued that medical facilities are becoming increasingly oriented towards cultivating an atmosphere in which such conversations could take place, and that it is not impossible to find a facility where staff are open to alternative views. I have also argued that it would not be impossible for some Aboriginal healing traditions (e.g. smudging) to be practiced within conventional health care delivery timeframes, but not all. However, I question why Aboriginal healing traditions must fit into such a timeframe. Crystal gives an example of Elder services that are provided at the walk-in clinic where she works, offered outside standard medical appointment timeframes:

Crystal: We've got a program, a diabetes program upstairs, and we do have an Elder working in that program so our pre-diabetic patients or patients that are at risk of diabetes—there's not supposed to be anybody with diabetes only the ones that are possibly going to get it—

Elena: Ok

Crystal: Ya, Health Canada rules, so they do have an Elder working there and they do a lot of the, they go to the circle and people are referred to her and that's the only one we have on site but she doesn't see our regular patients she just sees the diabetic patients.

Indeed, it is possible to bring AHT practitioners into medical facilities to consult patients and to provide some Aboriginal healing traditions (healing/talking circles). The challenge however appears to be obtaining funds for non-specific Elder services.

Last, I would like to comment on Blackbird's belief that Aboriginal healing traditions should not be mixed with Western medicine because they have to get a foothold *away* from the "polluting" effects of the biomedical paradigm. Whereas I have argued that it is possible to find atmospherically pleasing health care facilities; that it is possible to find health care providers who do support Aboriginal healing traditions; and that Aboriginal healing traditions need not be delivered within conventional health care

delivery timeframes, that Aboriginal healing traditions have to get away from biomedical paradigmatic constraints, I argue, is *not* reconcilable. At least it is not at this point in time. In contrast to Lentendre (2002) and Broome & Broome (2007), who point out that the integration of Aboriginal and Western medicine is problematic because, for example, traditional medicinal knowledge attributes healing power to the Creator whereas Western medicine attributes it to physicians, I argue instead that integration is problematic because *Western medicine ascribes more power to physicians than it does to AHT practitioners*, a problem that is further compounded by the vulnerability of Aboriginal healing traditions (namely Blackbird's traditions) to begin with: The combination is treacherous. Unless physicians and other authoritative figures renounce their authority and/or superiority in medical contexts where users and practitioners of AHT are involved, users and practitioners of AHT *should not* get involved. At present, the only medical contexts in which this is a real possibility are integrative medical contexts—facilities in which biomedicine is not given primacy, but rather is viewed as one of many medical models. The facilities where Jay and Denver work are two such examples.

In light of this argument, Fraser's (2003) status model of recognition *as a viable means to integrate Aboriginal healing traditions into urban medical facilities* must be reconsidered. Recall in Chapter 4, section 4.3, I propose that Aboriginal healing traditions might be readily accepted if health care culture replaces the value pattern "treat everyone the same" with the value pattern "honor patients' individual needs". However, *if* health care culture adopts such a value pattern, does it actually mean that patients have more say / control / authority than physicians insofar as their treatment options go? Does it mean that patients get to have their way and physicians do not? And, at the end of the

day, is the value pattern “honor patients’ individual needs” still effective if physicians are opposed to the means by which patients believe their needs should be met? I argue, no. My position, then, is this: Even if we systematically replace the value pattern “treat everyone the same” with the value pattern “honor patients’ individual needs”, users and practitioners of AHT will still be subject to the power relations that the biomedical paradigm upholds. That is to say, the will and/or authority of physicians and other authoritative figures (e.g. clinic managers) will take precedence over the needs and preferences of patients other practitioners who have less authority (e.g. nurses, AHT practitioners). Such being the case, if Aboriginal healing traditions are going to be integrated into urban medical facilities with integrity, what needs replacing is far more profound than the value pattern “treat everyone the same”: What needs replacing are the relations of power that the biomedical paradigm upholds. Put simply, the beliefs, needs, and preferences of the people who use and practice Aboriginal healing traditions must be deemed as important as those of physicians and other authoritative figures.

Chapter Seven

Participants Views: Aboriginal healing traditions should be integrated into urban medical facilities

In the first half of this chapter, section 7.1, I present the view articulated by participants that Aboriginal healing traditions should be integrated into urban medical facilities to provide urban-based Aboriginal people with increased choice and access to care, and to raise public awareness that Aboriginal healing traditions are well-needed and that they “work”. The question of diversity—across and within Aboriginal cultures—is also discussed. In the latter half of this chapter, section 7.2, I re-examine Anne Phillips’s concept of culture in light of participants’ views, and argue that Aboriginal healing traditions should only be integrated into urban medical facilities where physicians and other authoritative figures are open to alternative views, willing to renounce their authority, and accept the efficacy of Aboriginal healing traditions on the terms of its practitioners.

7.1 Awareness / access / choice

Should Aboriginal healing traditions be integrated into urban medical facilities? According to Isabelle, the answer is yes. In the excerpt below, Isabelle is commenting on the use of Aboriginal healing traditions in conventional medical facilities, integrative medical facilities, and culture specific centers. I wanted to know if she thought one type of facility was better suited to the task than others and this is what she said:

Isabelle: There has to be an acknowledgement and recognition that it needs to be in all the places that you’ve mentioned because *there’s such diversity in our communities*: We come from the four directions and we’re not necessarily from [this province] and we’re not necessarily from [this city], all of those things, so taking all that into consideration, having it separate and apart works best, *having it within a hospital would be really good for raising awareness and raising the*

acknowledgment that there is a need for it and that there is recognition that this is something that works and then having it in a place where everything is brought together from all different peoples [e.g. integrative medical facilities] that again, it's raising the awareness, it's sharing.

To be sure, Isabelle is supportive of bringing Aboriginal healing traditions into urban medical facilities and other medical contexts for two reasons: On the one hand, she believes that increased exposure will show the general public that Aboriginal healing traditions are in demand and that they “work”. On the other hand, she believes that increased access to Aboriginal healing traditions will better serve the city's diverse Aboriginal population. Susie too emphasized the importance of choice and/or access with respect to the use of Aboriginal healing traditions:

Susie: There will be individuals that want to have access to only Aboriginal services and then there are Aboriginals who don't want any access, but you need to give them that choice.

Susie: I like [the idea of] having another healing centre that integrates all that [alternative therapies] because there is so much to learn from each and, as an Aboriginal person, I don't want to be restricted to just having Aboriginal access to Aboriginal organizations; *I want to have access period.*

As indicated by these excerpts, diversity across and within Aboriginal cultures is a factor influencing Isabelle and Sally's views on integration: Their statements imply that Aboriginal healing traditions should be made available in as many contexts as possible because: a) Aboriginal healing traditions are greatly diverse; and b) Aboriginal individuals have unique preferences with regards to therapies and therapeutic contexts.

I agree with Isabelle and Susie. I am aware of the diversity across and within Aboriginal cultures, and I too think Aboriginal people should have access to any and all kinds of healing modalities including Aboriginal healing traditions. In fact, I think Aboriginal people—as members of the political body “Aboriginal”; the collective body

that is in colonial relations with the Canadian state—should be granted the opportunity to access whichever therapies they see fit for redressing past and present manifestations of colonial oppression.⁵¹ However, returning to Isabelle and Susie's view that Aboriginal healing traditions should be integrated into urban medical facilities and other medical contexts, one is obliged to ask: How should urban medical facilities endeavour to accommodate Aboriginal healing traditions given the diversity across and within Aboriginal cultures?

Indeed, "diversity" emerged as one of the major themes in my data. In the excerpt below, Crystal is talking about a particular Aboriginal healing center (in another Canadian city) that had problems getting underway because of diversity:

Crystal: They've been struggling for two years to get it right and it needs to go through so many avenues to get it—even within their own culture there's so many different pieces that it's difficult for an Aboriginal person to get it off the ground never mind somebody who doesn't know anything—so it's a big roadblock because if *they* can't do it after two years, how can *we* possibly do it properly?

Leonard and I had a lengthy discussion about diversity, however, unlike Crystal, the issue was not overwhelming to him. When I asked him how the Aboriginal addictions society where he works manages diversity, this is what he said:

Leonard: If you've got a Cree here, an Inuit, somebody from a Mi'kmaq, from Nova Scotia, all through, Ojibway, I don't care what it is, they come here, and what we do here ...we tell people: they may not pass the feather around; they may not pass the stick; they may not pass a stone; but we're here to teach you this because we are a whole bunch of mixtures of Aboriginals here. If you feel that what we're doing here is not right, that's ok, but you go back and learn your teachings: *This is just to get you started.*

And indeed, Leonard's attitude towards the use of Aboriginal healing traditions within urban medical facilities is comparable:

⁵¹ Waldram (1997) has argued that Aboriginal spirituality, as a measure of symbolic healing, is capable of redressing psychological, emotional, and spiritual damage done to Aboriginal peoples through colonization.

Leonard: You don't have to make it any one Aboriginal way right, because obviously it's impractical, but as long as they can go into a room and something's there to identify for them and the other Nations they're fine because we accept each other, we fight in politics, but we accept each other.

Here, Leonard is saying that there has to be a general space where Aboriginal peoples—those individuals who are in relations with the Canadian state—may convene in biomedical contexts. Such a space need not be “any one Aboriginal way” but should be able to accommodate culture-specific traditions.⁵² To be specific, this is how he visualizes such a space:

Leonard: If you're going to have a room like that, they [Aboriginal people] want to be comfortable. Color is important, you know ...you know, just like it's simple, and you can make your sash, you could have beautiful First Nations Art work ...stuff that means something to everybody.

Looking back onto Isabelle and Susie's comments in sections 5.1 and 5.2—about the dominant society accepting Aboriginal healing traditions and recognizing them as efficacious—these Aboriginal health administrators are pushing for institutional recognition of the political body “Aboriginal”; they would like the Canadian government to recognize, at the institutional level, the wrong doings done to Aboriginal peoples through colonization and residential schooling. In this chapter, however, Isabelle and Susie are pushing for the recognition of the diversity across and within individual Aboriginal cultures. They, like Leonard, are pushing for the recognition of a) the political body “Aboriginal”; and b) cultural diversity across and within Aboriginal cultures.

I think Phillip's (2007) concept of culture serves this discussion very well. In her book *Multiculturalism without Culture*, Phillips argues for an understanding of culture

⁵² As a note, Leonard is not exactly referring to Aboriginal healing traditions as defined in the introduction of this thesis: He is referring to Aboriginal approaches to health and medicine more generally.

much like that of gender and class: “something that influences, shapes, and constrains behaviour, but does not determine it” (p. 10). More specifically, she writes:

It ought to be possible to recognised the relevance of culture without concluding that it dictates all actions, and it ought to be possible to recognise that some individuals are coerced by cultural or religious pressures without concluding that all individuals are. It has been proved reasonably easy to manage this maneuver in relation to class and gender. It ought to be possible to do this with culture as well (p. 126).

This “careful” understanding of culture, as compared to “the overly homogenized versions that currently figure in the arguments of supporters and critics alike...will dispense with strong notions of culture” (p. 9). She argues in effect, “a defensible multiculturalism will put human agency much more at its centre” (p. 9). In other words, Phillips is arguing for agent-centered cultural entities—that is, demarcated cultural groups whose constituents are not passive and homogenous, but rather active and distinguishable. In the context of this chapter, within this discussion about diversity, I believe that Phillips’ concept of culture represents the kind of cultural recognition that Isabelle, Susie, and Leonard seek to establish: externally strong (distinguishable between groups) and internally flexible (distinguishable between individuals).

7.2 Discussion

Isabelle and Susie’s reasons for wanting to proceed with integration are certainly legitimate and, as this thesis has shown, it is indeed possible (although not easy) to bring some Aboriginal healing traditions into urban medical facilities. However, as this thesis has also shown, the circumstances under which Aboriginal healing traditions can be integrated *with integrity* are limited to facilities in which: 1) staff are open to alternative views; 2) physicians and other authoritative figures renounce their authority; and 3) the

efficacy of Aboriginal healing traditions is defined by its practitioners. Such being the case, I maintain that Aboriginal healing traditions should not be integrated into urban medical facilities unless these three conditions are met.

And what is to be made of my argument for Phillips' concept of culture? Does not Phillips' concept of culture legitimate both: a) the political body "Aboriginal"; and b) the diverse collection of healing traditions that this political body encompasses? Indeed it does, but unless this concept translates into the creation of physical space for Aboriginal healing traditions, then such a concept is *practically* useless. In other words, even if physicians and other authoritative figures support Phillips' concept of culture, but are not open to alternative views (about medicine); are not willing to renounce their authority; and are not willing to accept the efficacy of Aboriginal healing traditions as defined by its practitioners, then Phillips' concept of culture is futile. In effect, Phillips' concept of culture is only truly effective if and when it is mobilized by physicians and authoritative figures who are open to alternative views, willing to renounce their authority, and accept the efficacy of Aboriginal healing traditions on the terms of its practitioners. I apologize for being so repetitious but I feel it necessary to get my point across. This, I argue, is something that may be accomplished by way of policy, e.g., "the beliefs, needs, and preferences of people who use and practice Aboriginal healing traditions are as important as those of physicians and other authoritative figures", which would in practice amount to the allocation of funds and/or physical space for the use of Aboriginal traditions in all of their complexities. That is to say, any and all of the practical means through which Aboriginal healing traditions are realized would be afforded sufficient space, and the

users and practitioners of AHT would have a say in what, when, where, and how Aboriginal healing traditions are employed.

8.1 Summary of participants' views

Some of the participants in this study feel that the use of Aboriginal healing traditions within urban medical facilities is acceptable provided they do not impinge upon: 1) the will of physicians; 2) the user's "normal" physiological status; and 3) the health and recovery of other patients, whereas others feel that integration will only be "successful" (i.e. viewed favorably by users and practitioners of AHT as well as health care providers, health administrators, and other patients) if: 1) members of the dominant society accept Aboriginal healing traditions; 2) members of the dominant society recognize Aboriginal healing traditions as efficacious; 3) health care providers are open to alternative views; 4) Aboriginal people trust members of the dominant society; and 5) there is an increase in Aboriginal health care providers. Still, others are opposed to integration for the following reasons: 1) medical environments are not conducive to conversation; 2) Aboriginal healing traditions have to get "a foothold" without having to deal with biomedical paradigmatic constraints; and 3) Aboriginal healing traditions take more time than the current scheduling of medical appointments allows. Those participants who believe Aboriginal healing traditions *should* be integrated into urban medical facilities do so in conjunction with the expectation that increased access to Aboriginal healing traditions will, in turn, promote Aboriginal healing traditions and give urban-based Aboriginal people more choice.

In addition to these views, participants articulated all of the challenges put forth in preexisting literature. The challenge "appropriation and/or commodification of

Aboriginal healing traditions” is very much related to the challenge “distrust of the dominant society”. As Jeremy pointed out, “Aboriginal people don’t much trust the rest of society”, and he is worried that traditional Aboriginal knowledge risks appropriation. In connection to this, I have argued that it is both limiting and patronizing to withhold the use of Aboriginal healing traditions within urban medical facilities until Aboriginal people foster trust in the dominant society: Whether an Aboriginal person chooses to share his or her traditional knowledge with the rest of society is his or her choice to make. My views on this matter are traceable to Isabelle and Susie’s comments about choice and access. Overall, participants met the challenge “distrust of the dominant society” optimistically. In Chapter 5, section 5.6, participants identified a couple of “solutions” to this challenge. These included: 1) time in and of itself; and 2) increase the number of Aboriginal health care providers. Note, the latter has nothing to do with encouraging Aboriginal people to foster trust in the dominant society, but it does, in effect, eliminate the challenge “distrust of the dominant society” *as a barrier* to Aboriginal healing traditions. This is so, according to some of the participants, because: 1) Aboriginal health care providers have connections to healers; and 2) experiential knowledge is trustworthy—Aboriginal patients may feel more comfortable asking Aboriginal health care providers about Aboriginal healing traditions.

Likewise, the challenges “members of the dominant society have to accept Aboriginal healing traditions” and “members of the dominant society have to recognize Aboriginal healing traditions as efficacious” were viewed as situations that could be resolved either in time, via education, or via emotionally impressive, one-on-one opportunities to gain cultural knowledge directly from Aboriginal people. Also, Ellen’s

observation—health care providers have to be open to alternative views—was optimistic. Integrative medical physicians Jay and Denver are living proof that this is possible.

In spite of these views, I have argued that the task of getting members of the dominant society to accept Aboriginal healing traditions as efficacious in the absence of conventional proof presents a challenge even for those people like Denver who are open to and accepting of alternative views. The same can be said for people who learn about Aboriginal healing traditions: Individuals who know about Aboriginal healing traditions are not necessarily exempt from judging them by biomedical standards. For this reason, I argue here, Waldram's (1997) advice—people have to accept Aboriginal healing traditions as efficacious on the terms of its practitioners—is imperative. Although it may be difficult for some to accept, it is perhaps the only sure solution. In fact, I can think of no other way to address the challenge “liability and/or insurance”.

Remuneration was indeed identified as a challenge, but not an insurmountable one. If we consider Susie and Leonard's comments—that payment in the form of money (honorarium) is increasingly acceptable—as well as Smiling Stone's comments—that he expects *some* form of compensation for sitting in an office all day—we see that this challenge is under constructive evolution: Negotiations are underway.

8.2 The use of Aboriginal healing traditions in urban medical facilities: The researcher's perspective

Upon examining health care scholarship pertaining to health care delivery models, I have argued that both culturally competent health care and cultural safety are *not* designed to integrate Aboriginal healing traditions into urban medical facilities: The former because its central aim is to facilitate the flow of biomedical care, and the latter

because its central aim is to ameliorate Aboriginal/non-Aboriginal patient-provider relationships. Epstein's model of patient-centered care, I have argued, has the most potential because it puts the locus of therapeutic efficacy on patients' involvement in their care. As such, it would take the pressure off Aboriginal healing traditions from having to prove that they are efficacious and/or it would take the pressure off the dominant society from having to accept Aboriginal healing traditions on the terms of its practitioners. On the contrary, however, as shown in Chapter 4, several of the participants who do adopt the patient-centered model of care—that is, they believe health care should be based on individuals' needs—opted that Aboriginal healing traditions should be practiced *elsewhere* (not in medical facilities) in fear that they: a) might take space away from physicians and/or risk “stepping on physicians' toes”; b) would not be able to adhere to health care's rushed appointment timeframes; or c) would put health care providers in a position in which they would be providing preferential treatment. In other words, a willingness to reproduce the biomedical framework (e.g., physicians as the authority, rushed doctor-patient visits, and the commitment to treat all patients “the same”) overrides the patient-centered model of care. Such being the case, I argue: neither cultural competence nor cultural safety *nor* patient-centered care are capable of creating a situation in which Aboriginal healing traditions can be employed with integrity.

Whereas I argue that some challenges are reconcilable, e.g. “medical environments are not conducive to conversation” and “Aboriginal healing traditions take more time than conventional medical appointments will allow”, I have argued that the challenge “Aboriginal healing traditions have to get a foothold without having to deal with biomedical paradigmatic constraints” *is not*—at least not at this point in time. My

reasons for taking this position are as follows. Upon examining Fraser's (2003) status model of recognition as a viable means to formally integrate the use of Aboriginal healing traditions into urban medical facilities, I have found that even if the value pattern "honor patients' individual needs", replaces the value pattern "treat everyone the same", users and practitioners of AHT will still be subject to the power relations that the biomedical paradigm upholds. That which is in need of replacement, I have argued, is more profound than value patterns within health care culture: What needs replacement are the relations of power that the biomedical paradigm upholds, which, ultimately, represent and reproduce the status quo of power relations in the wider Canadian society.

I maintain this line of reasoning in Chapter 7 where I argue that Phillips' (2003, 2007) understanding of culture is only practically useful in health care contexts if it translates into the creation of physical space for Aboriginal healing traditions—an endeavour, I have argued, that can only manifest in health care contexts in which physicians and authoritative figures are open to alternative views, willing to renounce their authority, and willing to accept the efficacy of Aboriginal healing traditions on the terms of its practitioners. To be sure, the kind of health care context that I am depicting is one that relinquishes the attitudes, assumptions, and relations of power that the biomedical paradigm upholds—in other words, a health care context in which the biomedical paradigm is no longer *the* paradigm.

This research has sought to expand our understanding of the challenges involved in bringing Aboriginal healing traditions into urban medical facilities. In effect, I believe it has implications for health care delivery at large: No health care experience can be truly patient-centered so long as the attitudes, assumptions, and relations of power that

the biomedical paradigm upholds take precedence. Moreover, with the value pattern such as “treat everyone the same” embedded in health care culture, anyone’s request to use therapies other than those supported within the biomedical framework risk rejection. In fact, “abnormal” requests of any kind are liable to be turned down in the wake of health care providers who seek to treat all patients “the same” or who are apprehensive about providing “preferential treatment”.

In conclusion, I recommend that Aboriginal healing traditions should only be integrated into urban medical facilities where health care providers and other staff conscientiously let go of the attitudes, assumptions, and relations of power that the biomedical paradigm upholds. This is to say, Aboriginal healing traditions should only be integrated into urban medical facilities where health care providers and staff accept that the efficacy of Aboriginal healing traditions cannot be measured using biomedical standards and, instead, leave that up to its practitioners. This is also to say, Aboriginal healing traditions should only be integrated into urban medical facilities where health care providers and staff have abandoned their commitment to treat all patients “the same”. All of this, in effect, is to say, Aboriginal healing traditions should only be integrated into medical facilities where the beliefs, needs, and preferences of the people who use and practice Aboriginal healing traditions are deemed as important as those of physicians and other authoritative figures.

8.3 Reflections and future research

In my efforts to address the question: *should Aboriginal healing traditions be integrated into urban medical facilities?*, I drew upon anthropological precepts about biomedicine, bodily ways of knowing, sensorial dimensions of healing, and

multiculturalism. I found that the anthropology of embodiment and the anthropology of the senses were most useful in helping me to illustrate participants' perspectives pertaining to holism and to the transmission and acquisition of knowledge. Critical medical anthropology and feminist theory provided me with the theoretical framework to establish my main argument and, ultimately, to answer the question this thesis seeks to address. However, perhaps closer to the truth is that it was the assemblage of these theoretical perspectives, combined with the participants' views as well as my own, that together inform this research.

I would also like to comment on the implications of this research in comparison to James Waldram's work in Canadian prisons. Whereas Waldram's research seeks to establish Aboriginal spirituality as an efficacious therapy, I have suggested that Aboriginal healing traditions might fare better in health care contexts if they are in fact recognized as "religion" for the simple reason: religion has more political sway than "culture" (i.e. culture-based therapies). However, in consideration of my main argument—Aboriginal healing traditions should only be integrated into urban medical facilities where the beliefs, needs, and preferences of the people who use and practice Aboriginal healing traditions are deemed as important as those of physicians and other authoritative figures—then it does not matter if we are talking about Aboriginal healing traditions in terms of "religion" or "culture": If the beliefs, needs, and preferences of the *people* who use and practice smudging, for example, are deemed as important as those of physicians and other authoritative figures, then it does not matter if smudging is a component of "religion" or "culture" because it is not the traditions that have political sway but the *people* who use and practice them.

Given that some individuals who use Aboriginal healing traditions are not Aboriginal, a word about “users of AHT” is in order. To be sure, public and academic interest in bringing Aboriginal and Western medicine together, to be practiced within the same structure, is aimed at providing culturally appropriate health care to urban-based *Aboriginal* people. For example, in the introduction of this thesis, I state that the suggestion to bring Aboriginal healing traditions into urban medical facilities is traceable to health care research that shows Aboriginal people would benefit from a holistic model of care as defined by Aboriginal people and in relation to Aboriginal worldviews. Adopting this view, I go on to argue that Aboriginal people should be granted the opportunity to access whichever therapies they see fit for redressing past and present manifestations of colonial oppression. And when I state that Aboriginal healing traditions should only be integrated into urban medical facilities where the beliefs, needs, and preferences of the people who use and practice Aboriginal healing traditions are deemed as important as physicians and other authoritative figures, the people to whom I am implicitly referring are Aboriginal. Admittedly, this is a limitation of my main argument, and ultimately my research, because it does not provide a framework for the involvement of non-Aboriginal users or practitioners of AHT. Quite simply, my argument does not afford a space (ideological or physical) within Canada’s healthcare system for non-Aboriginal users of AHT. Indeed, non-Aboriginal involvement with Aboriginal healing traditions is a contentious issue (which I discuss to some extent in Chapters 3 and 5) and certainly deserves more attention than is allocated here. However, I would like to take this opportunity to point out: if the Canada’s health care system was truly patient-centered, and truly honored the beliefs, needs, and preferences of each and every patient,

then the creation of a space within Canada's health care system for non-Aboriginal users of AHT would be superfluous.

Taking into account the spectrum of arguments considered over the span of this thesis, I think it is useful, by way of closing, to point to one possible alternative solution to the challenge of integrating Aboriginal healing traditions within urban medical facilities. This solution would be to forego such facilities and consider some of the respects in which Aboriginal cultural centers might be better suited to the task. Given that Aboriginal cultural centers are indeed *native hubs*; they are chief networking sites for both reserve and urban-based Aboriginal people, I encourage research that explores the potential for Aboriginal cultural centers to connect urban-based Aboriginal people with Aboriginal healing traditions, as well as research that explores the potential for Aboriginal cultural centers to establish working relationships with urban medical facilities whereby the former provides consultation services to health care providers who wish to learn more about Aboriginal healing traditions or who wish to connect patients with AHT practitioners. This, of course, would entail a redirection of federal or provincial funds to Aboriginal cultural centers, as it would be unfair to expect these organizations to absorb the costs of hosting such a service. In addition to this, I encourage research that explores the potential for Aboriginal healing traditions to be integrated into integrative medical facilities. Given that medical facilities of this type do not typically adhere to the attitudes, assumptions, and relations of power that the biomedical paradigm upholds, research in this domain has merit.

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Appendices

Appendix A: Interview Questions for Practitioners of AHT⁵³

This interview is to explore the idea of bringing Aboriginal healing traditions into urban medical facilities.

(A) Demographic: Age; Gender; Occupation; Ethnicity.

(B) Background:

1. Where are you from, where did you grow up?
2. If not from this city, what brought you here?
3. How long have you lived here?

(C) Terminology:

1. The term “Aboriginal healing traditions” denotes a specific set of skills and practices. I would say that Aboriginal approaches to health and medicine are in a different category. Would you differentiate these as I have done?
2. I am curious about Aboriginal healing and curing traditions: What kind of activities come to mind when I say Aboriginal healing traditions?

(D) Becoming an Elder:

1. I am under the impression that becoming an Elder and/or a healer doesn’t just happen over night. I imagine it is something that one either discovers or develops in time? Maybe one has to work to cultivate it? Maybe one is born with it?

(E) Working in Medical Facilities:

1. What sorts of environments do you work in?

*Are some places more appropriate to work in than others? Do certain environments facilitate your work and ultimately the healing process better than others?

* To what extent does the healing environment help to restore your patients’ health?

*How often do you work in medical clinics (hospitals and/or clinics)?

⁵³ Upon interviewing Ellen, a user of AHT, I used this interview format as a rough guide

- I imagine this must be unfamiliar to many or most medical staff members?

- How do your clients and/or patients (the people you see) get in touch with you?

- Do you often see individuals more than once?

2. Which practices pose problems within medical environments and why do you think they pose problems? (e.g. hospital regulations, unwilling staff members)?

3. Is it possible to maintain a low profile when working in medical establishments? How do you maintain your clientele?

4. What do you think needs to happen in order for Aboriginal healing traditions to be accommodated into medical clinics (Administration wise and structurally)?

5. At this point, within medical facilities, which practices could be integrated with the least amount of difficulty? Can you make any recommendations as to how this might be accomplished?

6. Do you think there should be a clinic devoted entirely to Aboriginal approaches to health or medicine? What about an integrative medical facility? What about sensory-friendly medical facilities?

(F) The Application of Aboriginal Healing Traditions:

1. What range of illnesses do you feel comfortable treating?

2. How do you decide which traditions to use?

3. Are there particular healing traditions for people in critical states of health and alternately are there particular practices for those in less critical states?

(G) Notions of Health and Holism:

1. When people talk about holistic health, what does that mean to you? How would you or do you achieve holism in your life –what are some of the things you do to be holistic?

2. How do the human senses (sight, sound, touch, taste, smell) play a part in Aboriginal healing traditions and in your patients' recoveries?

(H) Non-Aboriginal Use of Aboriginal Healing Traditions:

1. The last time we met we talked a bit about the problems with non-Aboriginal peoples and companies gaining access to Aboriginal approaches to health and medicine and in some cases, patenting traditional herbal remedies. How would you like to see the general non-aboriginal population involved –what do you think would be the most respectful and appropriate way for the public to benefit from Aboriginal healing and curing traditions?
2. What is the most appropriate way to teach non-aboriginal medical community about traditional healing practices?
3. Do you think that teaching the non-Aboriginal medical community (or the rest of Canadian society) about Aboriginal approaches to health and medicine is a good way for Aboriginal peoples to gain acceptance from the “dominant” society?
4. Keeping a low profile seems to be an important part of maintaining your healing traditions, are there certain aspects of your healing practices that you have to be particularly careful about?
5. Do you feel that Aboriginal approaches to health and medicine are increasingly accepted by the dominant society?

Appendix B: Interview Questions for Health Administrators

This interview is to explore the idea of bringing Aboriginal healing traditions into urban medical facilities

(A) Demographic: Age; Gender; Funding.

(B) Work Experience: Role at health facility; How long at this facility; Previous experience working in health care facilities.

(C) Culturally Competent Health Care: *Culturally competent health is based on the idea that health care providers should be aware that different cultures have different beliefs and behaviors around health and that learning **about** the various ways in which cultures perceive and practice health, will help them to minimize cross-cultural misunderstandings.*

1. Are you familiar with any culturally competent health care models?
2. Is culturally sensitive health care or culturally competent health care incorporated into the clinic's ethos? For example are there any resources available for you and other staff to flip through? Any special training?
3. Does culturally competent health care, from what you've seen, have a taste, smell, feel or sound? Should it?

(D) Working with Aboriginal Peoples: *Aboriginal peoples are reported to have poor experiences using Canada's health care system due to cross-cultural misunderstanding and feelings of degradation.*

1. What is your impression of Aboriginal peoples' experiences at this facility?
2. Have any Aboriginal patients asked you (or other staff members) to see an Elder **at this clinic** or to bring in any traditional healing practices such as drumming, burning sage, etc, and if so what were the circumstances around that request?
3. Have any Aboriginal patients asked you (or other staff members) to see an Elder **in private**?

(E) Bringing Aboriginal Healing Traditions into Urban Medical Facilities:

1. What do you think about the use of Aboriginal healing traditions within urban medical facilities in terms of logistics (i.e. salary, insurance)?
2. In a facility like this one, to what extent could Aboriginal healing traditions be brought in? Which ones couldn't?

(F) Aboriginal-specific Clinic:

1. What are your thoughts on creating a clinic that is solely devoted to Aboriginal approaches to health and medicine as opposed to having an integrative clinic where Aboriginal approaches to health and medicine would be offered alongside a whole range of therapies (including biomedicine)?

(G) Miscellaneous:

1. Do you think it would be beneficial to replace cultural specific information with socio political information? For example, rather than teaching health care providers that Kwak'wak'wakw First Nations believe (x), would it be more helpful to teach them that residential schools were open until 1986, therefore, some Aboriginal patients may show signs of post traumatic stress.

2. In health care culture there is a creed to treat all patients equally. Can you explain this to me? How is this enacted (examples)? And how does this fit with the concept of culturally competent health care?

3. Do you have system set up to check the ethnic backgrounds of the patients that come in for treatment? Some clinics check languages for example.

4. One of the beliefs commonly shared by Aboriginal peoples across the country is that health is holistic—it's not limited to individual physiology: What does holism or holistic health mean to you?

5. How do you (or would you) achieve holism in your life—what are some of the things you do to be holistic?

6. Given that there are a lot of cultures in this world with a lot of different approaches to health, medicine, and wellness, rather than focusing on culture-specific medical facilities (that cater to particular cultural groups) what do you think bout sensory-friendly facilities? So, no matter what the practice, from no matter which culture, the facility can accommodate multi-sensorial dimensions (sound, smell, sights, tastes, etc)?